

11908

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>S. Division St</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>BENJAMIN</b> Last <b>ADKINS</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>5th</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 27, 1879</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.		IF UNDER 24 HRS. Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>John Adkins</b>				14. MOTHER'S MAIDEN NAME <b>Mary Timmons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>78</b>			
17. INFORMANT <b>Mrs. Eva V. Seney (Daughter)</b>				Address <b>3634 Elmley Ave. Baltimore 13, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Belat.</b> <b>492X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 wks.</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 Parkinsonism 2 Osteoarthritis</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 4, 1958</b> to <b>10/5</b> 1958, that I last saw the deceased alive on <b>9/30</b> 1958, and that death occurred at <b>5:10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Pine Bluff Rd. Salisbury, Maryland</b> DATE SIGNED <b>October 5 / 1958</b>							
ACTUAL SIGNATURE <b>Rufus S. Gardner Jr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. Rufus S. Gardner Jr. Pine Bluff Rd. Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Oct. 7, 1958</b>		<b>St. Johns Church Semetery - Fruitland, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>				24a. REC'D BY REGISTRAR <b>OCT 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11848

## CERTIFICATE OF DEATH

Reg. Dist. No.

11845

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 23X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Rt 4 #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Peggy</u> Middle <u>Sue</u> Last <u>Ayres</u>		4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1957</u>
9. AGE (In years last birthday) yrs. <u>11</u> Months <u>1</u> Days <u>1</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Reece Ayres</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Shackley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Name <u>Mrs Virginia Ayres</u> Address <u>Snow Hill, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, diffuse</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastroenteritis, acute, with dehydration</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>17 Oct</u> , 19 <u>58</u> , to <u>19 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 17</u> , 19 <u>58</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>K. W. Sundberg</u> M.D.		ADDRESS (Street, city or town, state) <u>707 Cambridge</u> DATE SIGNED <u>10/17/58</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Sumis</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll E. Francis</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11909 CERTIFICATE OF DEATH

11846

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>		c. LENGTH OF STAY IN 1b <b>27 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>	
3. NAME OF DECEASED (Type or print) First <b>EVA LAVINEA</b> Middle <b>BAKER</b> Last <b>BAKER</b>		4. DATE OF DEATH Month <b>10</b> Day <b>14</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/24/1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James E. Wilkins</b>		14. MOTHER'S MAIDEN NAME <b>Laura Truitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Harley Baker, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension - arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>5-8 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>day 7 death</b> , that I last saw the deceased alive on <b>10-13</b> , 19 <b>58</b> , and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Willards, Maryland</b> DATE SIGNED <b>10-14-1958</b> ACTUAL SIGNATURE <b>Frank R. Lewis</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Frank Lewis Willards, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/16/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Hope Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Willards, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 17 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Norman F. Baker</b>			

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11910 CERTIFICATE OF DEATH

11847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. LENGTH OF STAY IN 1b <b>40 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>300 Maryland Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>	
f. STREET ADDRESS <b>300 Maryland Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ralph Ashton Baker</b>		4. DATE OF DEATH Month Day Year <b>Oct. 6 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1889</b>
9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbing &amp; Heating</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Heating</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Noble Baker</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Collins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>221-10-2504</b>	
17. INFORMANT <b>Bertha M. Baker, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> to <b>10-6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9-10</b> , 19 <b>58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>303 East Street, Delmar</b> DATE SIGNED <b>10-7-58</b> ACTUAL SIGNATURE <b>L. V. Sokler</b> M.D. PHYSICIAN'S NAME (Type) <b>L. V. Sokler</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-9-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Red Mens</b>		22d. LOCATION (City, town, or county) (State) <b>Dagsboro, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Mangel Co - Delmar, Del</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 14 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. France</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. DATE OF DEATH April 4, 1968		6. TIME OF DEATH 2:01 PM	
7. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		8. CAUSE OF DEATH Shot		9. MANNER OF DEATH Suicide	
10. SIGNATURE OF DECEASED (None)		11. SIGNATURE OF WITNESS JAMES EARL RAY		12. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
13. SIGNATURE OF CORONER JAMES EARL RAY		14. SIGNATURE OF JURY JAMES EARL RAY		15. SIGNATURE OF JUDGE JAMES EARL RAY	
16. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		17. SIGNATURE OF CLERK JAMES EARL RAY		18. SIGNATURE OF REGISTRAR JAMES EARL RAY	
19. SIGNATURE OF CHIEF OF POLICE JAMES EARL RAY		20. SIGNATURE OF SHERIFF JAMES EARL RAY		21. SIGNATURE OF TOWNSHIP CLERK JAMES EARL RAY	
22. SIGNATURE OF COUNTY CLERK JAMES EARL RAY		23. SIGNATURE OF STATE CLERK JAMES EARL RAY		24. SIGNATURE OF NATIONAL CLERK JAMES EARL RAY	
25. SIGNATURE OF INTERNATIONAL CLERK JAMES EARL RAY		26. SIGNATURE OF DEPARTMENT CLERK JAMES EARL RAY		27. SIGNATURE OF BUREAU CLERK JAMES EARL RAY	
28. SIGNATURE OF FIELD CLERK JAMES EARL RAY		29. SIGNATURE OF DISTRICT CLERK JAMES EARL RAY		30. SIGNATURE OF COUNTY CLERK JAMES EARL RAY	
31. SIGNATURE OF TOWNSHIP CLERK JAMES EARL RAY		32. SIGNATURE OF STATE CLERK JAMES EARL RAY		33. SIGNATURE OF NATIONAL CLERK JAMES EARL RAY	
34. SIGNATURE OF INTERNATIONAL CLERK JAMES EARL RAY		35. SIGNATURE OF DEPARTMENT CLERK JAMES EARL RAY		36. SIGNATURE OF BUREAU CLERK JAMES EARL RAY	
37. SIGNATURE OF FIELD CLERK JAMES EARL RAY		38. SIGNATURE OF DISTRICT CLERK JAMES EARL RAY		39. SIGNATURE OF COUNTY CLERK JAMES EARL RAY	
40. SIGNATURE OF TOWNSHIP CLERK JAMES EARL RAY		41. SIGNATURE OF STATE CLERK JAMES EARL RAY		42. SIGNATURE OF NATIONAL CLERK JAMES EARL RAY	
43. SIGNATURE OF INTERNATIONAL CLERK JAMES EARL RAY		44. SIGNATURE OF DEPARTMENT CLERK JAMES EARL RAY		45. SIGNATURE OF BUREAU CLERK JAMES EARL RAY	
46. SIGNATURE OF FIELD CLERK JAMES EARL RAY		47. SIGNATURE OF DISTRICT CLERK JAMES EARL RAY		48. SIGNATURE OF COUNTY CLERK JAMES EARL RAY	
49. SIGNATURE OF TOWNSHIP CLERK JAMES EARL RAY		50. SIGNATURE OF STATE CLERK JAMES EARL RAY		51. SIGNATURE OF NATIONAL CLERK JAMES EARL RAY	
52. SIGNATURE OF INTERNATIONAL CLERK JAMES EARL RAY		53. SIGNATURE OF DEPARTMENT CLERK JAMES EARL RAY		54. SIGNATURE OF BUREAU CLERK JAMES EARL RAY	
55. SIGNATURE OF FIELD CLERK JAMES EARL RAY		56. SIGNATURE OF DISTRICT CLERK JAMES EARL RAY		57. SIGNATURE OF COUNTY CLERK JAMES EARL RAY	
58. SIGNATURE OF TOWNSHIP CLERK JAMES EARL RAY		59. SIGNATURE OF STATE CLERK JAMES EARL RAY		60. SIGNATURE OF NATIONAL CLERK JAMES EARL RAY	
61. SIGNATURE OF INTERNATIONAL CLERK JAMES EARL RAY		62. SIGNATURE OF DEPARTMENT CLERK JAMES EARL RAY		63. SIGNATURE OF BUREAU CLERK JAMES EARL RAY	
64. SIGNATURE OF FIELD CLERK JAMES EARL RAY		65. SIGNATURE OF DISTRICT CLERK JAMES EARL RAY		66. SIGNATURE OF COUNTY CLERK JAMES EARL RAY	
67. SIGNATURE OF TOWNSHIP CLERK JAMES EARL RAY		68. SIGNATURE OF STATE CLERK JAMES EARL RAY		69. SIGNATURE OF NATIONAL CLERK JAMES EARL RAY	
70. SIGNATURE OF INTERNATIONAL CLERK JAMES EARL RAY		71. SIGNATURE OF DEPARTMENT CLERK JAMES EARL RAY		72. SIGNATURE OF BUREAU CLERK JAMES EARL RAY	
73. SIGNATURE OF FIELD CLERK JAMES EARL RAY		74. SIGNATURE OF DISTRICT CLERK JAMES EARL RAY		75. SIGNATURE OF COUNTY CLERK JAMES EARL RAY	
76. SIGNATURE OF TOWNSHIP CLERK JAMES EARL RAY		77. SIGNATURE OF STATE CLERK JAMES EARL RAY		78. SIGNATURE OF NATIONAL CLERK JAMES EARL RAY	
79. SIGNATURE OF INTERNATIONAL CLERK JAMES EARL RAY		80. SIGNATURE OF DEPARTMENT CLERK JAMES EARL RAY		81. SIGNATURE OF BUREAU CLERK JAMES EARL RAY	
82. SIGNATURE OF FIELD CLERK JAMES EARL RAY		83. SIGNATURE OF DISTRICT CLERK JAMES EARL RAY		84. SIGNATURE OF COUNTY CLERK JAMES EARL RAY	
85. SIGNATURE OF TOWNSHIP CLERK JAMES EARL RAY		86. SIGNATURE OF STATE CLERK JAMES EARL RAY		87. SIGNATURE OF NATIONAL CLERK JAMES EARL RAY	
88. SIGNATURE OF INTERNATIONAL CLERK JAMES EARL RAY		89. SIGNATURE OF DEPARTMENT CLERK JAMES EARL RAY		90. SIGNATURE OF BUREAU CLERK JAMES EARL RAY	
91. SIGNATURE OF FIELD CLERK JAMES EARL RAY		92. SIGNATURE OF DISTRICT CLERK JAMES EARL RAY		93. SIGNATURE OF COUNTY CLERK JAMES EARL RAY	
94. SIGNATURE OF TOWNSHIP CLERK JAMES EARL RAY		95. SIGNATURE OF STATE CLERK JAMES EARL RAY		96. SIGNATURE OF NATIONAL CLERK JAMES EARL RAY	
97. SIGNATURE OF INTERNATIONAL CLERK JAMES EARL RAY		98. SIGNATURE OF DEPARTMENT CLERK JAMES EARL RAY		99. SIGNATURE OF BUREAU CLERK JAMES EARL RAY	
100. SIGNATURE OF FIELD CLERK JAMES EARL RAY		101. SIGNATURE OF DISTRICT CLERK JAMES EARL RAY		102. SIGNATURE OF COUNTY CLERK JAMES EARL RAY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11849 CERTIFICATE OF DEATH

11848

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>203 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nanticoke</b>	
d. STREET ADDRESS <b>--</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Ulie Barclay</b> Last <b>---</b>		4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Ulie Barclay</b>		14. MOTHER'S MAIDEN NAME <b>Ann Elsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>217-14-8227</b>	
17. INFORMANT <b>Deer's Head State Hospital, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelonephritis, chronic</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>---</b> DUE TO (c) <b>---</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>---</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 3, 19 58</b> , to <b>October 23, 19 58</b> , that I last saw the deceased alive on <b>October 23, 19 58</b> , and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital, Salisbury, Maryland</b> DATE SIGNED <b>10/24/58</b>			
ACTUAL SIGNATURE <b>Dr. V. Juerman</b>		M.D. <b>Deer's Head State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>		<b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10-26-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>NANTICOKE CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>NANTICOKE, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. T. Stewart</b>		ADDRESS <b>Funeral Home, Salisbury, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 29 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11850 CERTIFICATE OF DEATH

11849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alberta</b> Middle <b>Barkley</b> Last <b>Barkley</b>		4. DATE OF DEATH Month <b>October</b> Day <b>2</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/11/1882</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia Wright Halland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk. No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple myeloma</b> <b>203x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease with aortic stenosis, decomp.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 29</b> , 19 <b>58</b> , to <b>Oct. 2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct. 2</b> , 19 <b>58</b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. V. Juerman</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Deer's Head State Hospital 10/2/58</b>	
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>		<b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 6 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Seaford Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Seaford Del</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Boaker</b>		24a. REC'D BY REGISTRAR <b>8 '58</b>	
ADDRESS <b>110 West</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>	

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
OFFICE OF THE ASSISTANT ATTORNEY GENERAL  
1501 CALIFORNIA STREET, SUITE 1500  
SAN FRANCISCO, CALIFORNIA 94109  
TELEPHONE (415) 774-2000  
FAX (415) 774-2001  
WWW.CALIFORNIA.GOV/HEALTH

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial-transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11850

## 11851 CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 10/1/58</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Deal Island</u>		19 X - 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Minnie Herman Bennett</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Oct. 29 19 58</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>August 10, 1875</u>	<b>9. AGE last birthday</b> <u>83</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Deal Island, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>James G. Webster</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elnora Webster</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Pine Bluff State From Medical Records of Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>331X IMMEDIATE CAUSE (A)</b> <u>Cerebral Hemorrhage</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 day</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Pulmonary Tuberculosis</u>						<u>5 yrs.</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY - street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>Oct. 1, 19 58</u> , to <u>Oct. 29, 19 58</u> , that I last saw the deceased alive on <u>Oct. 29, 19 58</u> and that death occurred at <u>3:05 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>L. L. Lawry</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Fruitland, Md.</u>		<b>DATE SIGNED</b> <u>10/29/58</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Nov. 2-1958</u>		<b>NAME OF CEMETERY</b> <u>St. John's</u>		<b>LOCATION (City, town, or county)</b> (State) <u>Deal Island Ind</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>L. G. Webster</u> ADDRESS <u>Deal Island</u>			
<b>DATE</b> <u>NOV. 5 '58</u>							

# STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

File No.

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Time of death

8. Cause of death

9. Place of death

10. Name of physician

11. Name of attending physician

12. Name of medical examiner

13. Name of coroner

14. Name of registrar

15. Name of clerk

16. Name of assistant clerk

17. Name of stenographer

18. Name of typewriter

19. Name of messenger

20. Name of janitor

21. Name of porter

22. Name of watchman

23. Name of night watchman

24. Name of caretaker

25. Name of superintendent

26. Name of assistant superintendent

27. Name of clerk

28. Name of assistant clerk

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Time of death

8. Cause of death

9. Place of death

10. Name of physician

11. Name of attending physician

12. Name of medical examiner

13. Name of coroner

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16. Name of assistant clerk

17. Name of stenographer

18. Name of typewriter

19. Name of messenger

20. Name of janitor

21. Name of porter

22. Name of watchman

23. Name of night watchman

24. Name of caretaker

25. Name of superintendent

26. Name of assistant superintendent

27. Name of clerk

28. Name of assistant clerk

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Time of death

8. Cause of death

9. Place of death

10. Name of physician

11. Name of attending physician

12. Name of medical examiner

13. Name of coroner

14. Name of registrar

15. Name of clerk

16. Name of assistant clerk

17. Name of stenographer

18. Name of typewriter

19. Name of messenger

20. Name of janitor

21. Name of porter

22. Name of watchman

23. Name of night watchman

24. Name of caretaker

25. Name of superintendent

26. Name of assistant superintendent

27. Name of clerk

28. Name of assistant clerk

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Time of death

8. Cause of death

9. Place of death

10. Name of physician

11. Name of attending physician

12. Name of medical examiner

13. Name of coroner

14. Name of registrar

15. Name of clerk

16. Name of assistant clerk

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19. Name of messenger

20. Name of janitor

21. Name of porter

22. Name of watchman

23. Name of night watchman

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25. Name of superintendent

26. Name of assistant superintendent

27. Name of clerk

28. Name of assistant clerk

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Time of death

8. Cause of death

9. Place of death

10. Name of physician

11. Name of attending physician

12. Name of medical examiner

13. Name of coroner

14. Name of registrar

15. Name of clerk

16. Name of assistant clerk

17. Name of stenographer

18. Name of typewriter

19. Name of messenger

20. Name of janitor

21. Name of porter

22. Name of watchman

23. Name of night watchman

24. Name of caretaker

25. Name of superintendent

26. Name of assistant superintendent

27. Name of clerk

28. Name of assistant clerk

RECEIVED

RECEIVED



11852

## CERTIFICATE OF DEATH

11851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>Sussex</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD</u> 46X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA General Hospital</u>		d. STREET ADDRESS <u>OMAR ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>BREASURE</u> Last <u>BREASURE</u>		4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/19</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>	
11. BIRTHPLACE (State or foreign country) <u>DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WM. H. DONAWAY</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Clogg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>FRANKFORD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Negative Failure</u> 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced Coronary of Insar (Primary)</u> DUE TO (c) <u>gen.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>all for past gen.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>Oct. 9, 1958</u> , that I last saw the deceased alive on <u>Oct. 9, 1958</u> , and that death occurred at <u>1:15</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Hunter R. Maffi, M.D.</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10/12/58</u>	<u>Red Man Cemetery</u>	<u>Dagsboro - Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24b. REGISTRAR'S SIGNATURE	
<u>Ronald James - Millsboro - Del.</u>		<u>Arthur S. Kraus</u>	
DATE		DATE	
<u>Oct 16 '58</u>		<u>Oct 16 '58</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN DOE</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>10/15/1925</u></p>	
<p>5. Place of birth: <u>NEW YORK, N.Y.</u></p>		<p>6. Date of death: <u>11/10/1970</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>11/15/1970</u></p>		<p>12. Place of registration: <u>NEW YORK, N.Y.</u></p>	

11911

## CERTIFICATE OF DEATH

11852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Haven</u>		c. LENGTH OF STAY IN TB <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Haven</u>	
		f. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NORVELL H. COOPER</u>		4. DATE OF DEATH Month Day Year <u>Oct. 31 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer &amp; laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Jonah Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Richard Cooper, Salisbury, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X Pulmonary Tuberculosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 13</u> , 19 <u>58</u> , to <u>Oct 31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>58</u> , and that death occurred at <u>12 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alberta Mattax</u>		DATE SIGNED <u>Nov 3 '58</u>	
PHYSICIAN'S NAME (Type)		ADDRESS	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockawalkin Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rockawalkin, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Messier</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>	
ADDRESS <u>Bivalve, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		INDUSTRY		BUSINESS		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		GRADUATE		POSTGRADUATE		OTHER			
RELIGION		METHODIST		BAPTIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		OTHER			
CAUSE OF DEATH		DISEASE		INJURY		POISON		SUFFOCATION		HANGING		OTHER			
MANNER OF DEATH		NATURAL		ACCIDENTAL		SUICIDE		HOMICIDE		OTHER					
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH					
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN					
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE					

TO OBTAIN A COPY OF THIS FORM, APPLY TO THE BALTIMORE HEALTH DEPARTMENT, 100 BALTIMORE STREET, BALTIMORE, MARYLAND.

11853

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>219 W. Phila. Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>CUSHING</b> Last <b>DANA</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>22nd</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1873</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>22</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman - Retired -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Feed Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Chelsea, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Francis William Dana</b>		14. MOTHER'S MAIDEN NAME <b>Olive Locke Neale</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Richard C. Dana (Son) 219 W. Phila. Ave. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Insufficiency</b> DUE TO <b>myocardial Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C.V. Disease</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 19 58</b> to <b>10/22/58</b> , that I last saw the deceased alive on <b>10/22/58</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm B. Smith</b> M.D. <b>Wed. Carter Bldg., Md.</b>		DATE SIGNED <b>10/22/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. William B. Smith</b>		<b>Salisbury, Maryland Oct. 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 25, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lawncroft Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Bridgeport, Conn.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24a. REC'D BY REGISTRAR <b>SALISBURY MARYLAND</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hana</b>		DATE <b>OCT 27 58</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





11854

## CERTIFICATE OF DEATH

11854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>				c. LENGTH OF STAY IN 1b <b>3 yrs 14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Moses</b> Middle <b>William</b> Last <b>Dashiell</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>5,</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 30, 1863</b>	9. AGE (In years last birthday) <b>95</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardening</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Moses Dashiell</b>				14. MOTHER'S MAIDEN NAME <b>Flora Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Insufficiency</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pyelonephritis chr.</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular disease w/aortic sclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month <b>19</b>	Day <b>19</b>	Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 21,</b> 19 <b>55,</b> to <b>Oct. 5,</b> 19 <b>58,</b> that I last saw the deceased alive on <b>Oct. 5,</b> 19 <b>58,</b> and that death occurred at <b>5:25 AM,</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. V. Juerman</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>				DATE SIGNED <b>10/5/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 5-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mordella Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Mordella Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Barbara A. West</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>OCT 14 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11855

DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
PERIOD OF ILLNESS		PREVIOUS ILLNESS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PERSONAL HISTORY		PHYSICAL EXAMINATION	
LABORATORY EXAMINATIONS		PATHOLOGICAL FINDINGS	
POST-MORTEM EXAMINATION		AUTOPSY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11855

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11856

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

11856

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Berlin

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Peninsula General Hospital

d. STREET ADDRESS

RFD # 3

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

Charles LEE Davis

4. DATE OF DEATH

10-9-

19 58

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

MAR. 13, 1956

9. AGE (In years last birthday)

2 1/2 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Salisbury MD

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES H. DAVIS

14. MOTHER'S MAIDEN NAME

DOROTHY MERRITT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

MRS. C. H. DAVIS BERLIN MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Poisoning

INTERVAL BETWEEN ONSET AND DEATH

5 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b) Sodium Arsenite

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?  
YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Drank from soft drink bottle used to mix weed killer.

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.

19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Farm

20f. (City or town)

Berlin,

(County)

Worcester Co., Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Earl L. Royer

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

10-10-58

22a. BURIAL, CREMATION, or REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

10/11/58

22c. NAME OF CEMETERY OR CREMATORY

BETH EDEN

22d. LOCATION (City, town, or county)

SIVORY HILL MD (RFD)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Anna D. Burroughs Berlin Md

24a. REC'D BY REGISTRAR

DATE OCT 14 '58

24b. REGISTRAR'S SIGNATURE

Arthur S. House

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF  
NEW YORK

1888

STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

WILLIAM

WILLIAM

WILLIAM

WILLIAM'S GENERAL HISTORY

WILLIAM

WILLIAM

WILLIAM

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10-10-30



11856

## CERTIFICATE OF DEATH

11857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. STREET ADDRESS <b>906 Register St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VICTOR</b> Middle <b>McLAIN</b> Last <b>DEAN</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>4th</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1910</b>
9. AGE (In years last birthday) <b>48</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Wingate, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Richard Dean</b>		14. MOTHER'S MAIDEN NAME <b>Lehr Holliday</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Rosezena Dean (Wife)</b>		Address <b>806 Register St Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>200.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignant Tumor of Abdominal Lymph Nodes, Unclassified.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>490X</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 1, 1958</b> to <b>Oct. 4, 1958</b> , that I last saw the deceased alive on <b>Oct. 4, 1958</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>222 N. Division St. Salisbury, Md.</b> DATE SIGNED <b>Oct. 5, 1958</b>			
ACTUAL SIGNATURE <b>Paul G. Cayaves</b> M.D.		DATE SIGNED <b>Oct. 5, 1958</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Paul G. Cayaves</b>		ADDRESS <b>222 N. Division St. Salisbury, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 8, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 10 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11912

CERTIFICATE OF DEATH

11858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>DIXON</u> Last <u>DIXON</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>29</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/9/1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>30</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Elsey</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Leonard Brown, Tyaskin, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Occlusion.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease.</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour.</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 Aug</u> 19 <u>47</u> to <u>29 Oct</u> 19 <u>58</u> that I last saw the deceased alive on <u>29 Oct</u> 19 <u>58</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city or town, state) <u>Nanticoke, Md.</u> DATE SIGNED <u>10/30/58</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				<u>Nanticoke, Maryland</u> <u>10/30/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tyaskin Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Tyaskin, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. B. Messick</u> ADDRESS <u>Bivalve, Maryland</u>				24a. REG'D BY REGISTRAR <u>NOV 5 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1912	
AGE		SEX	
45		Male	
RACE		OCCUPATION	
White		Farmer	
BIRTH DATE		BIRTH PLACE	
JANUARY 1, 1867		BALTIMORE, MARYLAND	
MARRIAGE DATE		MARRIAGE PLACE	
JANUARY 1, 1890		BALTIMORE, MARYLAND	
CAUSE OF DEATH		PLACE OF DEATH	
Heart Disease		Home	
DISEASE		TREATMENT	
Angina Pectoris		None	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris	
DATE		DATE	
JANUARY 15, 1912		JANUARY 15, 1912	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11857

CERTIFICATE OF DEATH

Reg. Dist. No. 11859

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MORCISTEP</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>OCEAN CITY BLVD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>M.</u> Last <u>Fears</u>				4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 6, 1895</u>	
9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INTERIOR DECORATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>			
11. BIRTHPLACE (State or foreign country) <u>JONESBORO, ARK.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>ALFRED B. FEARS</u>				14. MOTHER'S MAIDEN NAME <u>ALICE VIRGINIA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES</u> <u>WORLDWART</u>				16. SOCIAL SECURITY NO. <u>327-12-2358</u>			
17. INFORMANT <u>MR. FRED FEARS</u>				Address <u>OCEAN CITY MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute</u> DUE TO (c) <u>day</u> INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>OCT 23</u> , 19 <u>58</u> , to <u>OCT 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>OCT 24</u> , 19 <u>58</u> , and that death occurred at <u>11:40</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Fears</u>			



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of medical examiner		19. Signature of pathologist		20. Signature of anatomist	
21. Signature of coroner		22. Signature of jury		23. Signature of witness		24. Signature of burial place	
25. Signature of funeral director		26. Signature of undertaker		27. Signature of cemetery		28. Signature of burial place	
29. Signature of health officer		30. Signature of medical examiner		31. Signature of pathologist		32. Signature of anatomist	
33. Signature of coroner		34. Signature of jury		35. Signature of witness		36. Signature of burial place	
37. Signature of funeral director		38. Signature of undertaker		39. Signature of cemetery		40. Signature of burial place	
41. Signature of health officer		42. Signature of medical examiner		43. Signature of pathologist		44. Signature of anatomist	
45. Signature of coroner		46. Signature of jury		47. Signature of witness		48. Signature of burial place	
49. Signature of funeral director		50. Signature of undertaker		51. Signature of cemetery		52. Signature of burial place	
53. Signature of health officer		54. Signature of medical examiner		55. Signature of pathologist		56. Signature of anatomist	
57. Signature of coroner		58. Signature of jury		59. Signature of witness		60. Signature of burial place	
61. Signature of funeral director		62. Signature of undertaker		63. Signature of cemetery		64. Signature of burial place	
65. Signature of health officer		66. Signature of medical examiner		67. Signature of pathologist		68. Signature of anatomist	
69. Signature of coroner		70. Signature of jury		71. Signature of witness		72. Signature of burial place	
73. Signature of funeral director		74. Signature of undertaker		75. Signature of cemetery		76. Signature of burial place	
77. Signature of health officer		78. Signature of medical examiner		79. Signature of pathologist		80. Signature of anatomist	
81. Signature of coroner		82. Signature of jury		83. Signature of witness		84. Signature of burial place	
85. Signature of funeral director		86. Signature of undertaker		87. Signature of cemetery		88. Signature of burial place	
89. Signature of health officer		90. Signature of medical examiner		91. Signature of pathologist		92. Signature of anatomist	
93. Signature of coroner		94. Signature of jury		95. Signature of witness		96. Signature of burial place	
97. Signature of funeral director		98. Signature of undertaker		99. Signature of cemetery		100. Signature of burial place	

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-15-2010 BY 60322  
UCBAW

11858

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glen St</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>	
3. NAME OF DECEASED (Type or print) First <b>EDDIE</b> Middle <b>LEE</b> Last <b>FIELDS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>26th</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>R.D.#(Shad Point) Salisbury, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Fields</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Fields</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Nettie Fields (Wife) Glen St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basal Cell Carcinoma of Left Shoulder</b> 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/24/58</b> to <b>10/24/58</b> , that I last saw the deceased alive on <b>10/24/58</b> , and that death occurred at <b>4:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Md</b> DATE SIGNED <b>Oct 30 / 1958</b>			
ACTUAL SIGNATURE <b>H. R. Gramse</b>		M.D. <b>Salisbury, Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Fred Gramse</b>		<b>S. Division St. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 29, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>R.D.# Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>NOV 3 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH-BALTIMORE, 11

11859

## CERTIFICATE OF DEATH

11861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>23x-2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY FOREMAN</u>				4. DATE OF DEATH Month Day Year <u>October 12 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6 1897</u>	
9. AGE (In years last birthday) <u>61 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hammer factory</u>			
11. BIRTHPLACE (State or foreign country) <u>Newark, MD</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Sidney Foreman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Fredow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>William H. Foreman</u>				Address <u>Newark, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac dilatation</u> <u>443X</u> DUE TO <u>chronic congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>491X</u> (b) <u>massive pleural effusion</u> (c) <u>hypertensive atherosclerotic C.V. disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u> <u>4 weeks</u> <u>Year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia, left. Atelectasis left. Emphysema,</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/11/58</u> to <u>10/11/58</u> , that I last saw the deceased alive on <u>10/11/58</u> , and that death occurred at <u>11:15</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Oct. 16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>William H. Foreman</u>		22d. LOCATION (City, town, or county) (State) <u>Newark, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne G. Gimmis</u> ADDRESS <u>Snow Hill, MD</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11860

## CERTIFICATE OF DEATH

11862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
c. LENGTH OF STAY IN TB <b>1 Day</b>		d. STREET ADDRESS <b>Park Ave., Apts.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ETHEL TULL FOSTER</b>		4. DATE OF DEATH Month Day Year <b>10 18 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1891</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Army Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nurse</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. Alfred Tull</b>		14. MOTHER'S MAIDEN NAME <b>Stella K. Tull</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. S. King White</b>		Address <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct, acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-17, 1958</b> , to <b>10-18, 1958</b> , that I last saw the deceased alive on <b>10-18, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Salisbury, Md. 10-1958</b>			
ACTUAL SIGNATURE <b>Wilber R. Ellis, Jr.</b>		M.D. <b>Salisbury, Md.</b>	
PHYSICIAN'S NAME (Type) <b>WILBER R. ELLIS, JR.</b>		<b>SALISBURY, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/20/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Marion Station, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co.</b>		ADDRESS <b>Salisbury, Maryland</b>	
24a. REC'D BY REGISTRAR <b>OCT 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krand</b>	



11861

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <b>October</b> Day <b>21</b> Year <b>19 58</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 19, 1904</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Frazier</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Keys</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>217-10-3617</b>		17. INFORMANT <b>Deer's Head State Hospital, Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of larynx, advanced</b> <b>161x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month <b>10</b>	Day <b>23</b>	Year <b>58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Salisbury Md</b>	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 20, 19 58</b> , to <b>October 21, 19 58</b> , that I last saw the deceased alive on <b>October 21, 19 58</b> , and that death occurred at <b>12:55 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. V. Juerman</b>				ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>10/21/58</b>			
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>				<b>Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>10-23-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deer's Head State Hospital</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>OCT 29 58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11862

## CERTIFICATE OF DEATH

11864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 22 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		d. STREET ADDRESS <b>107 E. Isabella St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>Owens</b> Last <b>Fulton</b>		4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/1/1879</b>
9. AGE (In years last birthday) <b>79 yrs.</b>		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Owens</b>		14. MOTHER'S MAIDEN NAME <b>Martha Porter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Jean Truitt-Brown</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor Pulmonale</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>Carcinoma of head of pancreas</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>30 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 18, 1958</b> , to <b>October 10, 1958</b> , that I last saw the deceased alive on <b>October 10, 1958</b> , and that death occurred at <b>11:10 M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Koshmahly</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>	
DATE SIGNED <b>10/11/58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Gerhard Koshmahly</b>		Deer's Head State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 13/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>OCT 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11863

## CERTIFICATE OF DEATH

Reg. Dist. No.

11865

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Berlin</u> <u>23X-2</u>			
3. NAME OF DECEASED (Type or print) <u>Charles E. Hadder</u>				4. DATE OF DEATH <u>October 29 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 1 1878</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MARYL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM H. HADDER</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. WIDGEON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MR. THOMAS HADDER SHOWELLS MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592X</u> DUE TO <u>Chronic glomerular nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Years.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Berlin</u>				20g. (County) <u>MD</u>		20h. (State)	
21. I certify that I attended the deceased from <u>10-10-58</u> to <u>10-29-58</u> , that I last saw the deceased alive on <u>10-28-58</u> , and that death occurred at <u>12:40</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>Berlin Md</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				DATE SIGNED <u>Nov 3 '58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/31/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TAY-ORVILLE</u>		22d. LOCATION (City, town, or county) <u>Berlin</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>NOV 3 '58</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G235 10/31/58 gg

11864

CERTIFICATE OF DEATH

11866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
c. LENGTH OF STAY IN 1b <b>30 yrs</b>				d. STREET ADDRESS <b>215 Newton St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>215 Newton St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Stephen Isadore Harrington</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 23, 1871</b>	
9. AGE (In years last birthday) <b>86</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Robert Pritchett</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Webster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Wendell Humphreys Salisbury Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/8</b> , 19 <b>58</b> , to <b>10/22</b> , 19 <b>58</b> ; that I last saw the deceased alive on <b>10/20</b> , 19 <b>58</b> , and that death occurred at <b>Md.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. R. Gramie</b>				ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b>			
PHYSICIAN'S NAME (Type) <b>James Thomson Preece</b>				DATE SIGNED <b>10/24/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 25 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>		22d. LOCATION (City, town, or county) (State) <b>Md. Vernon Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Thomson Preece</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. H. H.</b>	

# CERTIFICATE OF DEATH

W. C. C. C. C.

2011-11-11

212 Newton St.

Stephen

Female White

Housewife

Robert Pritchett

Mr

Mr

2011-11-11

212 Newton St.

Isadore Hershberg

Male White

Mr

Pauline Webster

Mr Mendell Thompson

Mr

Mr

Robert Pritchett

Isadore Hershberg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11867

11865

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>843 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Disharoon</b> Last <b>Harris</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/8/1899</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	9. AGE (In years last birthday) <b>59</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Dinstan</b>		14. MOTHER'S MAIDEN NAME <b>Trieze</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mr. Ernest J. Disharoon (Son)</b>		Address <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>30</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>July 9, 1956</b> , to <b>Oct. 30, 1958</b> , that I last saw the deceased alive on <b>October 30, 1958</b> , and that death occurred at <b>10:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. V. Maldve</b>		DATE SIGNED <b>10/31/58</b>	
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		ADDRESS <b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 3, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 3 '58</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



11

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11868  
Reg. Dist. No.

11866

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Pen Gen Hospital</b>		d. STREET ADDRESS <b>1000 E.Church St</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>WILLIAM</b> Last <b>HARRISON</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>3rd</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>21</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Deal Island, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Harrison</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Cole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mrs. Lula L. Harrison (Wife)</b>		Address <b>1000 E.Church St Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		DATE SIGNED <b>October 6 /1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 7th /58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bivalve Meth.Church Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Bivalve, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24a. REC'D BY REGISTRAR <b>OCT 10 '58</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



11867

CERTIFICATE OF DEATH

11869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen. Hospital</b>		e. STREET ADDRESS <b>U.S. Route #50 R.D.#(Ocean City Road)</b>	
3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>COMSTOCK</b> Last <b>HAWKINS</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>9th</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Single</b>	8. DATE OF BIRTH <b>Jan. 28, 1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner &amp; Operator (Glass Shop)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woonsocket, R.I.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Benoni Hawkins</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Mills</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Miss Miriam J. Hawkins (Sister)</b>		Address <b>R.D.#(Ocean City Road) Route #50 Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-8</b> , to <b>10-9</b> , 19 <b>58</b> . That I last saw the deceased alive on <b>10-8</b> , 19 <b>58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip A. Insley</b>		ADDRESS (Street, city or town, state) <b>116 E. Main St. Salisbury, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b>		DATE SIGNED <b>October 10 / 58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 13 / 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woonsocket, R.I.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>OCT 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kross</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

## 11868 CERTIFICATE OF DEATH

11870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>MAY</u> Last <u>HAYMAN</u>		4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 14, 1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WICOMICO CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS BYRD</u>		14. MOTHER'S MAIDEN NAME <u>ETHEL WALLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-09-8918</u>	
17. INFORMANT <u>ALBERT HAYMAN</u>		Address <u>MARDELA SPRINGS, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE (LEFT)</u> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>CHRONIC NEPHRITIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/11/1958</u> to <u>10/14/1958</u> , that I last saw the deceased alive on <u>10/13/1958</u> , and that death occurred at <u>5:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>SALISBURY, MD.</u>	
PHYSICIAN'S NAME (Type) <u>  </u>		DATE SIGNED <u>10-14-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 19, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OLD CHURCH CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MARDELA SPRINGS, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. FRAMPTON + SON</u>		ADDRESS <u>FEDERALSBURG, MD.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>OCT 17 1958</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

11868

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1873		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JAN 25 1938		BALTIMORE, MD.	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES H. HARRIS		MARY J. HARRIS		JANE HARRIS		JOHN HARRIS		HIGH SCHOOL		METHODIST	
DATE OF INTERVIEW		BY		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAN 26 1938		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11871

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

11869

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Penna. Railroad Bridge &amp; E. Main St</b>		e. STREET ADDRESS <b>922 Johnson St</b>	
3. NAME OF DECEASED (Type or print) <b>PAUL</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>5th</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>14</b> Hours <b>14</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Retired-</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Somerset Co. Maryland</b>	
13. FATHER'S NAME <b>Thomas Hitch</b>		14. MOTHER'S MAIDEN NAME <b>Annie Cantwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT <b>Mrs. Minnie Hitch (Wife)</b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>802x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Compound Fracture left orbit &amp; maxilla</b> DUE TO (c) <b>Sudden</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by train.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>10-5-</b> <b>58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>P.R.R. tracks.</b>		20f. (City or town) <b>Salisbury</b> (County) <b>Wicomico</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 8, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>OCT 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. L. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11872

Reg. Dist. No.

11870

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN IB <u>1 yr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>1918 Herbert St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Elizabeth</u> Last <u>Hood</u>		4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Larkins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 16, 1957</u> , to <u>Oct. 7, 1958</u> , that I last saw the deceased alive on <u>Oct. 7, 1958</u> , and that death occurred at <u>8:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>		DATE SIGNED <u>10/7/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/12/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Blatman</u>		ADDRESS <u>1201 M. Calloby</u>	
24a. REC'D BY REGISTRAR <u>Oct 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



## CERTIFICATE OF DEATH

11873  
Reg. Dist. No.

11871

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peh. Gen. Hospital</b>		e. STREET ADDRESS <b>510 Ann St</b>	
3. NAME OF DECEASED (Type or print) First <b>BARBARA</b> Middle <b>ANN</b> Last <b>HORSEMAN</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6th</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 5, 1958</b>
9. AGE (In years last birthday) <b>0</b>		10. IF UNDER 1 YEAR <b>0</b> Months <b>0</b> Days <b>14</b> Hours <b>17</b> Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		12. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13. BIRTHPLACE (State or foreign country) <b>Salisbury, Md.-Hospital</b>		14. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
15. FATHER'S NAME <b>George Carroll Horseman</b>		16. MOTHER'S MAIDEN NAME <b>Jo Ann Hearn</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>No</b>	
19. INFORMANT <b>Mr. George C. Horseman (Father)</b>		20. ADDRESS (Street, city or town, state) <b>510 Ann St Salisbury, Maryland</b>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 Atelectasis of both lung severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rematurity</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23a. TIME OF INJURY Hour <b>o. m.</b> <b>19</b> p. m.	23b. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	23d. (City or town) (County) (State)
24. I certify that I attended the deceased from <b>October 5, 1958</b> to <b>Oct 6, 1958</b> , that I last saw the deceased alive on <b>Oct 5th, 1958</b> , and that death occurred at <b>2:40 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>D. L. V. Sohler</b>		DATE SIGNED <b>October 5th 1958</b>	
PHYSICIAN'S NAME (Type) <b>Dr. L. V. Sohler</b>		ADDRESS <b>303 East Delmar, Maryland</b>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	25b. DATE THEREOF <b>Oct. 8, 1958</b>	25c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>	25d. LOCATION (City, town, or county) (State) <b>Laurel, Delaware</b>
26. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
27a. REC'D BY REGISTRAR <b>DATE OCT 10 '58</b>		27b. REGISTRAR'S SIGNATURE <b>Arthur L. Hearn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082161XV2



CERTIFICATE OF MARRIAGE

1937



NAME OF BRIDE		NAME OF GROOM	
MRS. J. M. BROWN		MR. J. M. BROWN	
DATE OF BIRTH		DATE OF BIRTH	
JAN. 1, 1900		JAN. 1, 1900	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
FATHER'S NAME		FATHER'S NAME	
J. M. BROWN		J. M. BROWN	
MOTHER'S NAME		MOTHER'S NAME	
J. M. BROWN		J. M. BROWN	
DATE OF MARRIAGE		DATE OF MARRIAGE	
JAN. 1, 1937		JAN. 1, 1937	
PLACE OF MARRIAGE		PLACE OF MARRIAGE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
OFFICIAL		OFFICIAL	
J. M. BROWN		J. M. BROWN	
DATE OF OFFICIAL		DATE OF OFFICIAL	
JAN. 1, 1937		JAN. 1, 1937	
PLACE OF OFFICIAL		PLACE OF OFFICIAL	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
SIGNATURE OF BRIDE		SIGNATURE OF GROOM	
J. M. BROWN		J. M. BROWN	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN. 1, 1937		JAN. 1, 1937	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
OFFICIAL		OFFICIAL	
J. M. BROWN		J. M. BROWN	
DATE OF OFFICIAL		DATE OF OFFICIAL	
JAN. 1, 1937		JAN. 1, 1937	
PLACE OF OFFICIAL		PLACE OF OFFICIAL	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11913 Item 9 Film 6235 11-5-58 et

### CERTIFICATE OF DEATH

11877

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Wicomico</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>			c. LENGTH OF STAY IN 1b <u>7 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <u>WINFIELD</u> <u>HORSMAN</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Oct.</u> <u>25</u> <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/25/1877</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>9</u>		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farm labor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John Horsman</u>				14. MOTHER'S MAIDEN NAME <u>Martha Bedsworth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or date of service) <u>World war #1</u>				17. INFORMANT Address <u>Mrs William Couch, Quantico, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> DUE TO <u>Generalized Arteriosclerosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours.</u> <u>10 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11 April, 1947</u> to <u>25 Oct, 1958</u> that I last saw the deceased alive on <u>25 Oct, 1958</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city or town, state) <u>Nanticoke Md.</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				DATE SIGNED <u>10/27/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bivalve Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bivalve, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Messick</u>				ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 31 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11874

11872

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital, Hebron Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annabelle Horsey</b>		4. DATE OF DEATH <b>Oct. 18 1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/30/ 1920</b>
9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mill</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>u. s. A.</b>	
13. FATHER'S NAME <b>Harland Morris</b>		14. MOTHER'S MAIDEN NAME <b>Julia Rider</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-05-3506</b>	
17. INFORMANT <b>Roland Horsey</b>		Address <b>Hebron Md. box 362</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Haemorrhage</b> <b>642.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Eclampsic Convulsions</b> DUE TO (c) <b>Toxaemia of Pregnancy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2+days</b> <b>2+days</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/16</b> , 19 <b>58</b> , to <b>10/18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/18</b> , 19 <b>58</b> , and that death occurred at <b>10:15A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Osborne Chris Jensen</b> M.D.		ADDRESS (Street, city or town, state) <b>321 S. DIVISION ST.</b> DATE SIGNED <b>10/22/58</b>	
PHYSICIAN'S NAME (Type) <b>OSBORNE D. CHRISTENSEN, M.D. SALISBURY, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>10/21/ 58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Quantico</b>	22d. LOCATION (City, town, or county) (State) <b>Quantico Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton F. Stewart</b>		ADDRESS <b>West Road Salisbury Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Place of death	
6. Cause of death		7. Nature of disease		8. Duration of disease		9. Date of onset		10. Date of admission to hospital	
11. Name of physician		12. Name of hospital		13. Name of attending physician		14. Name of medical examiner		15. Name of coroner	
16. Name of funeral home		17. Name of cemetery		18. Name of burial place		19. Name of interment place		20. Name of final resting place	
21. Name of next of kin		22. Name of executor		23. Name of administrator		24. Name of guardian		25. Name of trustee	
26. Name of executor		27. Name of administrator		28. Name of guardian		29. Name of trustee		30. Name of beneficiary	
31. Name of beneficiary		32. Name of beneficiary		33. Name of beneficiary		34. Name of beneficiary		35. Name of beneficiary	
36. Name of beneficiary		37. Name of beneficiary		38. Name of beneficiary		39. Name of beneficiary		40. Name of beneficiary	
41. Name of beneficiary		42. Name of beneficiary		43. Name of beneficiary		44. Name of beneficiary		45. Name of beneficiary	
46. Name of beneficiary		47. Name of beneficiary		48. Name of beneficiary		49. Name of beneficiary		50. Name of beneficiary	
51. Name of beneficiary		52. Name of beneficiary		53. Name of beneficiary		54. Name of beneficiary		55. Name of beneficiary	
56. Name of beneficiary		57. Name of beneficiary		58. Name of beneficiary		59. Name of beneficiary		60. Name of beneficiary	
61. Name of beneficiary		62. Name of beneficiary		63. Name of beneficiary		64. Name of beneficiary		65. Name of beneficiary	
66. Name of beneficiary		67. Name of beneficiary		68. Name of beneficiary		69. Name of beneficiary		70. Name of beneficiary	
71. Name of beneficiary		72. Name of beneficiary		73. Name of beneficiary		74. Name of beneficiary		75. Name of beneficiary	
76. Name of beneficiary		77. Name of beneficiary		78. Name of beneficiary		79. Name of beneficiary		80. Name of beneficiary	
81. Name of beneficiary		82. Name of beneficiary		83. Name of beneficiary		84. Name of beneficiary		85. Name of beneficiary	
86. Name of beneficiary		87. Name of beneficiary		88. Name of beneficiary		89. Name of beneficiary		90. Name of beneficiary	
91. Name of beneficiary		92. Name of beneficiary		93. Name of beneficiary		94. Name of beneficiary		95. Name of beneficiary	
96. Name of beneficiary		97. Name of beneficiary		98. Name of beneficiary		99. Name of beneficiary		100. Name of beneficiary	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11875  
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Home</b>		e. STREET ADDRESS <b>Cedar Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle <b>Anne</b> Last <b>Horsey</b>		4. DATE OF DEATH Month <b>10</b> Day <b>31</b> Year <b>58</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 16-58</b>
9. AGE (In years last birthday) yrs. <b>1</b> Months <b>11</b> Days <b>14</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>←</b>	
11. BIRTHPLACE (State or foreign country) <b>Fruitland Wicomico, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>←</b>	
13. FATHER'S NAME <b>LEONARD Horsey</b>		14. MOTHER'S MAIDEN NAME <b>Esther A COLLINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>←</b>		16. SOCIAL SECURITY NO. <b>←</b>	
17. INFORMANT <b>LEONARD Horsey</b>		Address <b>Cedar Lane Fruitland MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia.</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>←</b> (a), stating the underlying cause last. DUE TO (c) <b>←</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>←</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>←</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>←</b>		20f. (City or town) (County) (State) <b>←</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		DATE SIGNED <b>11-1-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur</b>		22b. DATE THEREOF <b>Nov 2-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Westover</b>		22d. LOCATION (City, town, or county) (State) <b>Westover Som MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H Ward</b>		ADDRESS <b>Manor MD</b>	
24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

2082264XV2



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 1917  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

NAME

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11873

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		e. STREET ADDRESS <u>Poplar St.</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>HORSEY</u> Middle <u></u> Last		4. DATE OF DEATH <u>OCTOBER 3, 1958</u> Month <u>October</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/16/1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salvor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Granville Horsey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Rodney Horsey, Fruitland Md</u> Address <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Glomerular nephritis</u> <u>590x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with uremia</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 20, 1958</u> to <u>Oct 3, 1958</u> , that I last saw the deceased alive on <u>10-3-58</u> , 19 <u>58</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lee L. Lawry</u>		ADDRESS (Street, city or town, and state) <u>Fruitland Md.</u> DATE SIGNED <u>10-3-58</u>	
PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	22d. LOCATION (City, town, or county) (State) <u>Fruitland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton Stewart Salis. Md.</u> ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>OCT 8 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Prange</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11874

## CERTIFICATE OF DEATH

11878

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>12</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital 408 W. Main St.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury 12</u> d. STREET ADDRESS <u>408 W. Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Barbara Burnadine Howard</u> First Middle Last		4. DATE OF DEATH <u>October 12- 1958</u> Month Day Year		9. AGE (In years last birthday) <u>2</u> yrs. <u>20 1/2</u> Min.			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>October 9- 1958</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Randolph O. Howard</u>			
14. MOTHER'S MAIDEN NAME <u>Barbara Moore</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Barbara Moore</u> Address <u>408 W. Main St. Salisbury Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atelectasis</u> DUE TO (c) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <u>Oct 9</u> , 1958, to <u>Oct 12</u> , 1958, that I last saw the deceased alive on <u>Oct 12</u> , 1958, and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>10/12/58</u>							
ACTUAL SIGNATURE <u>William C. Morgan</u>		PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Houston</u>			
22d. LOCATION (City, town, or county) <u>Salisbury</u>		22e. (State) <u>Md</u>		24a. REC'D BY REGISTRAR <u>Oct 20 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>Clinton O. Stewart</u>		24c. REGISTRAR'S SIGNATURE <u>Salis. Md</u>					

[illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11876

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 11880

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>2 wks</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>			d. STREET ADDRESS <u>Bivalue</u>		
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Larmon</u> Last <u>Bivalue</u>			4. DATE OF DEATH October <u>21</u> - 19 <u>58</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1885</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>McHenry Robertson</u>			14. MOTHER'S MAIDEN NAME <u>Mary Nester Wilson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Milton Larmon, Salisbury, Md.</u> Address <u>Salisbury, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/18</u> 19 <u>58</u> to <u>10/21</u> 19 <u>58</u> , that I last saw the deceased alive on <u>10/21</u> 19 <u>58</u> , and that death occurred at <u>1:38</u> M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>H. F. Briele</u>		M.D. <u>Medical Certificate</u>		DATE SIGNED <u>10/21/58</u>	
PHYSICIAN'S NAME (Type) <u>H. F. Briele</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bivalue Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bivalue, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Mesquite, Bivalue, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>ONE 2 8 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11877

## CERTIFICATE OF DEATH

Reg. Dist. No.

11881

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Route #1 23X-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Canvey CARVEY Leonard</u>		4. DATE OF DEATH Month Day Year <u>October 8- 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK LEONARD</u>		14. MOTHER'S MAIDEN NAME <u>Arlanta Timmons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>Mrs. Bertrude Leonard-Whaleyville, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>332X</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis with</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/10, 1958</u> to <u>10/8, 1958</u> , that I last saw the deceased alive on <u>10/8, 1958</u> , and that death occurred at <u>4:59 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>10/10/58</u>	
PHYSICIAN'S NAME (Type) <u>David J. Gilmore M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Peter's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Newark, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Stewart</u> ADDRESS <u>Funeral Home, Salisbury, Md</u>		24a. REC'D BY REGISTRAR <u>OCT 15 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Frank Leonard		11-28-28	
Age		Sex	
42		Male	
Married		Occupation	
Yes		Farmer	
Place of Birth		Cause of Death	
New York		Heart Disease	
Date of Burial		Place of Burial	
12-1-28		Cemetery	
Buried		Interment	
Yes		Yes	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Certificate		Place of Death	
11-28-28		Home	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11878

## CERTIFICATE OF DEATH

11882

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mapsville 83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Charlesville</u> Middle <u>Littleton</u> Last <u>Littleton</u>		4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK LITTLETON</u>		14. MOTHER'S MAIDEN NAME <u>JANE TATEM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. Ruby Casson, Rt 2 Newcastle</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 13, 1958</u> to <u>Oct. 16, 1958</u> , that I last saw the deceased alive on <u>Oct 16, 1958</u> , and that death occurred at <u>12:38 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, M.D.</u>		ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>10/16/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKSLEY</u>	22d. LOCATION (City, town, or county) (State) <u>PARKSLEY VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry M. Johnson, Parksley, Va.</u>		24a. REC'D BY REGISTRAR ADDRESS DATE <u>OCT 24 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11883

11879

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital.</u>				d. STREET ADDRESS <u>1000 1/2 St. 712 Goldsborough</u>															
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ernest</u> Middle <u>louis</u> Last <u>Maddux</u>				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>15</u> Year <u>1958</u>															
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 1, 1878</u>													
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee Ice Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>													
13. FATHER'S NAME <u>William B. Maddux</u>				14. MOTHER'S MAIDEN NAME <u>Virginia McCallister</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Bessie P. Maddux (Wife) 712 Goldsborough St. Salisbury, Maryland</u>															
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="vertical-align: top;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u>            DUE TO <u>902.0</u>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         </td> <td colspan="2" style="vertical-align: top;">           (b) <u>Fracture of Vertebrae and right 9th Rib</u>            DUE TO         </td> <td colspan="2" style="vertical-align: top;">           INTERVAL BETWEEN ONSET AND DEATH  <u>1 day</u> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;">           (c)         </td> <td colspan="2" style="vertical-align: top;">           DUE TO         </td> <td colspan="2" style="vertical-align: top;"> <u>1 day</u> </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u> DUE TO <u>902.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Fracture of Vertebrae and right 9th Rib</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		(c)		DUE TO		<u>1 day</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u> DUE TO <u>902.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Fracture of Vertebrae and right 9th Rib</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>															
(c)		DUE TO		<u>1 day</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall from tree at home.</u>																	
20c. TIME OF INJURY Hour <u>11</u> a. m. <u>30</u> ) Oct. <u>15</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>Kendrick Mc Cullough</u>		EXAMINER'S NAME (Type) <u>Kendrick Mc Cullough, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Oct. 15, 1958</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 17, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. # (Walston) Salisbury, Md</u>													
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>Oct 20 '58</u>													
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>				24c. REGISTRAR'S SIGNATURE															

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11884

## CERTIFICATE OF DEATH

11880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>12</u> <u>SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA General Hospital</u>		d. STREET ADDRESS <u>BOND STREET</u>	
3. NAME OF DECEASED (Type or print) <u>IRMA B. MASON</u>		4. DATE OF DEATH <u>October 5, 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKKEEPING SERVICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOOKKEEPER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM C. BREWINGTON</u>		14. MOTHER'S MAIDEN NAME <u>ISADORA WASHBURN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ELIZABETH ANN LYNCH, Pompano Beach, FLA.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Widespread metastatic carcinoma</u> <u>170X</u> DUE TO (b) <u>Adenocarcinoma of l. breast.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/3/58</u> , 19 <u>58</u> , to <u>10/5/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/5/58</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		M.D. <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10/8/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>SALISBURY Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert T. Wallace</u>		ADDRESS <u>Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11885

Reg. Dist. No.

11915

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Willards</b> <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Robert</b> First <b>Gordon</b> Middle <b>McDonald</b> Last		4. DATE OF DEATH Month <b>10-</b> Day <b>4-</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1906</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Credit Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accounting</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John A. Mc Donald</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Picard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>World #2</b>		16. SOCIAL SECURITY NO. <b>112-07-6023</b>	
17. INFORMANT <b>Mrs. Rosalia McDonald Willards Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b> <b>9731</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Lay on ground behind car exhaust</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>10-4</b> 19 <b>58</b> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Willards Wicomico Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		DATE SIGNED <b>10-7-58</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/ 8/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Farlows</b>	22d. LOCATION (City, town, or county) (State) <b>Pittsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 10 58</b>	
ADDRESS <b>Selbyville</b>		24b. REGISTRAR'S SIGNATURE <b>John A. Royer</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
Robert J. Jones		35		Male	
Residence		Occupation		Cause of Death	
1234 Main St., Baltimore, Md.		Engineer		Heart Disease	
Date of Death		Time of Death		Place of Death	
Jan 15, 1968		10:30 AM		Home	
Physician		Medical Examiner		Manner of Death	
Dr. J. H. Smith		Dr. J. H. Smith		Natural	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report	
Jan 16, 1968		11:00 AM		Baltimore, Md.	

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First <b>Milton</b> Middle <b>-</b> Last <b>Morris</b>		4. DATE OF DEATH Month <b>October</b> Day <b>29th</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1876</b>
9. AGE (In years lost birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Frances Morris</b>		14. MOTHER'S MAIDEN NAME <b>Martha Hurst</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. --	
17. INFORMANT <b>Deer's Head State Hospital Records, Salisbury, Md.</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ca. of Prostate</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Salisbury</b>		(County) (State)
21. I certify that I attended the deceased from <b>July 30, 19 56</b> to <b>October 29, 19 58</b> that I last saw the deceased alive on <b>October 29, 19 58</b> and that death occurred at <b>3:38 PM</b> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>L. V. Maldve</b>		DATE SIGNED <b>10/29/58</b>
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		Salisbury, Maryland
22a. BURIAL, CREMATION, REMOVAL, SPECIFY	22b. DATE THEREOF <b>11/1/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>East New Market</b>
22d. LOCATION (City, town, or county) <b>East New Market, Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Murphy</b>		24a. REGISTERAR <b>W. S. Murphy</b>
ADDRESS <b>East New Market</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. Murphy</b>
DATE <b>11/1/58</b>		





11882

## CERTIFICATE OF DEATH

Reg. Dist. No.

11887

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mumford</u>		4. DATE OF DEATH Month Day Year <u>October 8 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 8, 1958</u>
9. AGE (In years last birthday) yrs. <u>1</u> <u>9</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert H. Mumford</u>		14. MOTHER'S MAIDEN NAME <u>Pearl Dashield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Albert H. Mumford, Salisbury, Md., R.F.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-8-58</u> , 19 <u>58</u> , to <u>10-8-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-8-58</u> , 19 <u>58</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Maryland</u> <u>10-8-1958</u>	
PHYSICIAN'S NAME (Type) <u>William C. Morgan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 10, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Old Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mardela Springs, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>		24a. REC'D BY REGISTRAR <u>14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

2182306XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

11-10-19

MINN  
ROM

<p>1. Name of deceased: <u>John J. Rom</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>11-10-19</u></p>		<p>4. Place of birth: <u>St. Paul, Minn.</u></p>	
<p>5. Date of death: <u>11-10-19</u></p>		<p>6. Place of death: <u>St. Paul, Minn.</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Name of informant: <u>John J. Rom</u></p>		<p>12. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>13. Name of informant: <u>John J. Rom</u></p>		<p>14. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>15. Name of informant: <u>John J. Rom</u></p>		<p>16. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>17. Name of informant: <u>John J. Rom</u></p>		<p>18. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>19. Name of informant: <u>John J. Rom</u></p>		<p>20. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>21. Name of informant: <u>John J. Rom</u></p>		<p>22. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>23. Name of informant: <u>John J. Rom</u></p>		<p>24. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>25. Name of informant: <u>John J. Rom</u></p>		<p>26. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>27. Name of informant: <u>John J. Rom</u></p>		<p>28. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>29. Name of informant: <u>John J. Rom</u></p>		<p>30. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>31. Name of informant: <u>John J. Rom</u></p>		<p>32. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>33. Name of informant: <u>John J. Rom</u></p>		<p>34. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>35. Name of informant: <u>John J. Rom</u></p>		<p>36. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>37. Name of informant: <u>John J. Rom</u></p>		<p>38. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>39. Name of informant: <u>John J. Rom</u></p>		<p>40. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>41. Name of informant: <u>John J. Rom</u></p>		<p>42. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>43. Name of informant: <u>John J. Rom</u></p>		<p>44. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>45. Name of informant: <u>John J. Rom</u></p>		<p>46. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>47. Name of informant: <u>John J. Rom</u></p>		<p>48. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>49. Name of informant: <u>John J. Rom</u></p>		<p>50. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>51. Name of informant: <u>John J. Rom</u></p>		<p>52. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>53. Name of informant: <u>John J. Rom</u></p>		<p>54. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>55. Name of informant: <u>John J. Rom</u></p>		<p>56. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>57. Name of informant: <u>John J. Rom</u></p>		<p>58. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>59. Name of informant: <u>John J. Rom</u></p>		<p>60. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>61. Name of informant: <u>John J. Rom</u></p>		<p>62. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>63. Name of informant: <u>John J. Rom</u></p>		<p>64. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>65. Name of informant: <u>John J. Rom</u></p>		<p>66. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>67. Name of informant: <u>John J. Rom</u></p>		<p>68. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>69. Name of informant: <u>John J. Rom</u></p>		<p>70. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>71. Name of informant: <u>John J. Rom</u></p>		<p>72. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>73. Name of informant: <u>John J. Rom</u></p>		<p>74. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>75. Name of informant: <u>John J. Rom</u></p>		<p>76. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>77. Name of informant: <u>John J. Rom</u></p>		<p>78. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>79. Name of informant: <u>John J. Rom</u></p>		<p>80. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>81. Name of informant: <u>John J. Rom</u></p>		<p>82. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>83. Name of informant: <u>John J. Rom</u></p>		<p>84. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>85. Name of informant: <u>John J. Rom</u></p>		<p>86. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>87. Name of informant: <u>John J. Rom</u></p>		<p>88. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>89. Name of informant: <u>John J. Rom</u></p>		<p>90. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>91. Name of informant: <u>John J. Rom</u></p>		<p>92. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>93. Name of informant: <u>John J. Rom</u></p>		<p>94. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>95. Name of informant: <u>John J. Rom</u></p>		<p>96. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>97. Name of informant: <u>John J. Rom</u></p>		<p>98. Address of informant: <u>St. Paul, Minn.</u></p>	
<p>99. Name of informant: <u>John J. Rom</u></p>		<p>100. Address of informant: <u>St. Paul, Minn.</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11883

## CERTIFICATE OF DEATH

Reg. Dist. No.

11888

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cecil G. Bland General Hospital</u>				d. STREET ADDRESS <u>West Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mumford</u>				4. DATE OF DEATH <u>October 8 - 1958</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 8, 1958</u>	
9. AGE (In years last birthday) yrs. <u>10</u>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Albert H. Mumford</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Dashield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Albert H. Mumford, Salisbury, Maryland</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Respiratory Failure</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>10-8-1958</u> to <u>10-8-1958</u> , that I last saw the deceased alive on <u>10-8-1958</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>10-8-1958</u>			
PHYSICIAN'S NAME (Type) <u>William C. Morgan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mardela Springs, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>Oct 14 '58</u> DATE _____		24b. REGISTRAR'S SIGNATURE <u>William S. Morgan</u>	

2282307XVO

CERTIFICATE OF DEATH

11222

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of burial place	
17. Signature of church		18. Signature of family		19. Signature of friends		20. Signature of neighbors	
21. Signature of community		22. Signature of society		23. Signature of association		24. Signature of organization	
25. Signature of institution		26. Signature of hospital		27. Signature of clinic		28. Signature of laboratory	
29. Signature of pharmacy		30. Signature of dispensary		31. Signature of store		32. Signature of business	
33. Signature of school		34. Signature of college		35. Signature of university		36. Signature of government	
37. Signature of military		38. Signature of naval		39. Signature of air force		40. Signature of space force	
41. Signature of coast guard		42. Signature of marine corps		43. Signature of army corps		44. Signature of navy corps	
45. Signature of air corps		46. Signature of space corps		47. Signature of coast guard		48. Signature of marine corps	
49. Signature of army corps		50. Signature of navy corps		51. Signature of air corps		52. Signature of space corps	
53. Signature of coast guard		54. Signature of marine corps		55. Signature of army corps		56. Signature of navy corps	
57. Signature of air corps		58. Signature of space corps		59. Signature of coast guard		60. Signature of marine corps	
61. Signature of army corps		62. Signature of navy corps		63. Signature of air corps		64. Signature of space corps	
65. Signature of coast guard		66. Signature of marine corps		67. Signature of army corps		68. Signature of navy corps	
69. Signature of air corps		70. Signature of space corps		71. Signature of coast guard		72. Signature of marine corps	
73. Signature of army corps		74. Signature of navy corps		75. Signature of air corps		76. Signature of space corps	
77. Signature of coast guard		78. Signature of marine corps		79. Signature of army corps		80. Signature of navy corps	
81. Signature of air corps		82. Signature of space corps		83. Signature of coast guard		84. Signature of marine corps	
85. Signature of army corps		86. Signature of navy corps		87. Signature of air corps		88. Signature of space corps	
89. Signature of coast guard		90. Signature of marine corps		91. Signature of army corps		92. Signature of navy corps	
93. Signature of air corps		94. Signature of space corps		95. Signature of coast guard		96. Signature of marine corps	
97. Signature of army corps		98. Signature of navy corps		99. Signature of air corps		100. Signature of space corps	

## CERTIFICATE OF DEATH

Reg. Dist. No.

11889

11884

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. STREET ADDRESS <b>224 Maryland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>McGAINTY</b> Last <b>MUNDT</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>16th</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7th, 1888</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR: Months <b>10</b> Days <b>9</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Patrick McGainty</b>		14. MOTHER'S MAIDEN NAME <b>Bridget Dunnion</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. James H. Mundt (Son)</b>		Address <b>R.D. # 2 Preston, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> DUE TO <b>330x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO <b></b> (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Insufficiency; Coronary Artery Heart Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Hour <b></b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) <b></b> (County) <b></b> (State) <b></b>
21. I certify that I attended the deceased from <b>8/10/1953</b> to <b>10/16/1958</b> , that I last saw the deceased alive on <b>Oct. 16, 1958</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David J. Gilmore</b>		ADDRESS (Street, city or town, state) <b>Medical Center, Salisbury, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Wilbur Ellis Jr.</b>		DATE SIGNED <b>October 18, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 20, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cem. (New Section)</b>	22d. LOCATION (City, town, or county) <b>Easton, Maryland</b> (State) <b></b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>OCT 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11916 CERTIFICATE OF DEATH

Reg. Dist. No. 11890

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>408 Chestnut Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b> f. STREET ADDRESS <b>408 Chestnut Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Cole Nock</b>		4. DATE OF DEATH Month Day Year <b>Oct. 3 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 28, 1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Trainman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Wm. Nock</b>		14. MOTHER'S MAIDEN NAME <b>Teresa Stewart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>716-03-1592</b>	
17. INFORMANT <b>Lena Nock, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis cerebral</b> DUE TO <b>and general</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> to <b>Oct 3, 1958</b> , that I last saw the deceased alive on <b>October 3, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. V. Sohler</b>		ADDRESS (Street, city or town, state) <b>East Street Delmar Md</b> DATE SIGNED <b>10-4-58</b>	
PHYSICIAN'S NAME (Type) <b>L. V. Sohler</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 5, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>First Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Delmar, Del.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Marvel Co. - Delmar, Del.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Carling L. Frank</b>			

CERTIFICATE OF DEATH

DECEASED NAME JAMES H. HARRIS		SEX MALE		AGE 68	
RACE WHITE		BIRTH DATE 1878		PLACE BALTIMORE, MD.	
OCCUPATION LABORER		RESIDENCE 103 CHESTNUT ST.		CITY BALTIMORE, MD.	
DATE OF DEATH 1918		TIME OF DEATH 10:00 AM		PLACE OF DEATH HOME	
CAUSE OF DEATH HEART DISEASE		DISEASE OR INJURY HEART DISEASE		MEDICAL HISTORY HEART DISEASE	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF DECEASED J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS	
SIGNATURE OF REGISTRAR J. H. HARRIS		SIGNATURE OF CLERK J. H. HARRIS		SIGNATURE OF JURY J. H. HARRIS	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11885 - CERTIFICATE OF DEATH

Reg. Dist. No.

11891

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Northampton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheriton</u> 83X.3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springhill Sanitarium</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>West</u> Last <u>Nottingham</u>				4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/12/86</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>		IF UNDER 24 HRS. Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>John B. Nottingham</u>				14. MOTHER'S MAIDEN NAME <u>Molly A. Hanby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT Address <u>Roy Nottingham Eastville, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-10-58</u> to <u>10-10-58</u> , that I last saw the deceased alive on <u>10-10-58</u> , 19 <u>58</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur S. Hanks</u> M.D. <u>Salisbury Md</u>				ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>10-10-58</u>			
PHYSICIAN'S NAME (Type) <u>Ph: I. P. A. Tinsley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cape Charles Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cape Charles, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11886

## CERTIFICATE OF DEATH

## 11892

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u> 1939.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alexander</u> First Middle Last		4. DATE OF DEATH <u>PAGE</u> Month <u>October</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 24 - 1884</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>Seaford Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Crisfield, Som. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Page</u>		14. MOTHER'S MAIDEN NAME <u>Leah Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>215-01-1111</u>	
17. INFORMANT <u>Father Page</u> Address <u>137 S. 4th St. Crisfield, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilman</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center, Salisbury</u> DATE SIGNED <u>10/14/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 16, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell</u>	22d. LOCATION (City, town, or county) (State) <u>Crisfield Som. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward-Marion</u> ADDRESS <u>Station, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 17 '58</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 11917 CERTIFICATE OF DEATH

11893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Haven</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x White Haven</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>K.</b> Last <b>POLK</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>22</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/20/1886</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b>	IF UNDER 24 HRS. Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oysterman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Benjamin Polk</b>				14. MOTHER'S MAIDEN NAME <b>Mary -----</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Garner Polk, White Haven, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.2</b> DUE TO <b>Chronic myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b> <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <b>20f. (City or town)</b> (County) (State) <b>21. I certify that I attended the deceased from Aug 21, 1958 to Oct 20, 1958, that I last saw the deceased alive on Oct 22, 1958, and that death occurred at 3:20 P.M. from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) <b>Hebron, Maryland</b> DATE SIGNED <b>Oct 23-58</b> ACTUAL SIGNATURE <b>William Emerich</b> M.D. <b>Hebron, Md.</b> PHYSICIAN'S NAME (Type) <b>William Emerich</b> <b>Hebron, Maryland 10/22/58</b> <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>10/26/58</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Polk Private Cem.</b> <b>22d. LOCATION (City, town, or county)</b> (State) <b>White Haven, Maryland</b> <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>C. B. W. Bivalse</b> <b>ADDRESS</b> <b>Bivalse, Maryland</b> <b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>OCT 28 '58</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15, 1950</i></p>		<p>5. TIME OF DEATH <i>10:00 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>10. OCCUPATION <i>Engineer</i></p>		<p>11. MARITAL STATUS <i>Married</i></p>		<p>12. EDUCATION <i>High School</i></p>	
<p>13. PREVIOUS ILLNESS <i>None</i></p>		<p>14. PRESENT ILLNESS <i>None</i></p>		<p>15. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>	
<p>16. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>17. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>18. SIGNATURE OF REGISTRAR <i>John Doe</i></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD. IT IS NOT VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD. IT IS NOT VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11887

CERTIFICATE OF DEATH

11894

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>WORCESTER</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>				c. LENGTH OF STAY IN 1b <i>2 WEEKS</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS <i>MARY</i>			
3. NAME OF DECEASED (Type or print) First <i>Edmond</i> Middle <i>Wise</i> Last <i>Powell</i>				4. DATE OF DEATH Month <i>October</i> Day <i>20</i> Year <i>1958</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>JUNE 19, 1886</i>	
				9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>REALTOR</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>REAL ESTATE</i>			
11. BIRTHPLACE (State or foreign country) <i>BERLIN MD</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>EDWIN J. POWELL</i>				14. MOTHER'S MAIDEN NAME <i>J. ANNIE WISE</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>217-050744</i>			
17. INFORMANT <i>MRS. ELIZABETH TAYLOR</i>				Address <i>BERLIN MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerosis</i> DUE TO <i>Tertiary Syphilis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>centurium</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>10-5-</i> , 19 <i>58</i> , to <i>10-20-</i> , 19 <i>58</i> , that I lost saw the deceased alive on <i>10-20-</i> , 19 <i>58</i> , and that death occurred at <i>8:35</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Salisbury, Md</i> DATE SIGNED <i>10-21-58</i>							
ACTUAL SIGNATURE <i>William S. Elliot</i> M.D.				PHYSICIAN'S NAME (Type) <i>Salisbury, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>10/23/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>EVERGREEN</i>		22d. LOCATION (City, town, or county) (State) <i>BERLIN MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna A. Burdige</i> ADDRESS <i>Berlin Md</i>				24a. REC'D BY REGISTRAR <i>OCT 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS

ADOLPHUS A. BOHNER

WILLIAM BOHNER

JOHN BOHNER

I hereby certify that the above is a true and correct copy of the original as filed in my office.	
Registrar of Vital Records	Date
State of Massachusetts	County of
City of	Town of
District of	Precinct of
Age	Sex
Race	Color
Marital Status	Cause of Death
Date of Death	Place of Death
Signature of Registrar	Signature of Physician

# CERTIFICATE OF DEATH

11895

Reg. Dist. No.

MEDICAL CERTIFICATION

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR'S CERTIFICATE** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1888

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

<p>NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>AGE</p> <p><i>45</i></p>		<p>SEX</p> <p><i>Male</i></p>	
<p>DATE OF DEATH</p> <p><i>Jan 15 1888</i></p>		<p>TIME OF DEATH</p> <p><i>10:30 AM</i></p>		<p>PLACE OF DEATH</p> <p><i>Home</i></p>	
<p>CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>PLACE OF BIRTH</p> <p><i>England</i></p>		<p>DATE OF BIRTH</p> <p><i>Jan 15 1843</i></p>	
<p>EDUCATION</p> <p><i>Common School</i></p>		<p>RELIGION</p> <p><i>Anglican</i></p>		<p>PREVIOUS ILLNESS</p> <p><i>None</i></p>	
<p>DATE OF INTERMENT</p> <p><i>Jan 17 1888</i></p>		<p>PLACE OF INTERMENT</p> <p><i>St. Paul's Church</i></p>		<p>NAME OF MINISTER</p> <p><i>Rev. J. H. Smith</i></p>	
<p>SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>		<p>SIGNATURE OF WITNESSES</p> <p><i>John Doe</i></p>		<p>SIGNATURE OF MINISTER</p> <p><i>Rev. J. H. Smith</i></p>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11896

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11889			
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>105 W. Philadelphia Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Allan</b> Last <b>Reynolds</b>		4. DATE OF DEATH Month <b>10</b> Day <b>28</b> Year <b>58</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 18-1929</b>
9. AGE (In years last birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months <b>29</b> Days <b>29</b> Hours <b>29</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL</b>	
11. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>PAUL E REYNOLDS</b>		14. MOTHER'S MAIDEN NAME <b>EVELYN M. COOKE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>217-28-3703</b>	
17. INFORMANT <b>Rev. Paul E. Reynolds, St. Michael Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed chest</b> <b>816X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Thrown from car involved in a collision.</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:20 A.M. 10-28-58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Dover &amp; Johnson</b>		20f. (City or town) (County) (State) <b>Salisbury Wicomico Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		DATE SIGNED <b>10-29-58</b>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 30, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oliver Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Michael Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Hamilton Harrison, St. Michael Md</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		DATE <b>NOV 5 '58</b>	

NEW YORK STATE DEPARTMENT OF HEALTH - BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1920

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
OFFICE OF EXAMINER: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11897

11890

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>223 New York Ave</b>		d. STREET ADDRESS <b>223 New York Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BETTIE</b> Middle <b>PARKER</b> Last <b>RICHARDSON</b>		4. DATE OF DEATH Month <b>OCT.</b> Day <b>30th</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 21, 1879</b>
9. AGE (In years lost birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James Redden</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Mitchell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Mrs. Charles A. Skirven (Daughter)</b>		Address <b>223 New York, Ave. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral hemorrhage</b> DUE TO (c) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>51</b> , to <b>Oct</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Oct 30</b> , 19 <b>58</b> , and that death occurred at <b>3 p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Alberta Mattax M.D.</b>		ADDRESS (Street, city or town, state) <b>711 Camden Ave. Salisbury, Maryland</b>	
DATE SIGNED <b>Oct. 31 / 1958</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Alberta Mattax</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 2, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>NOV 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11891

## CERTIFICATE OF DEATH

11898

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COROOKA</u> <u>20x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fannie</u> <u>MONTAGUE</u> <u>ROE</u>				4. DATE OF DEATH Month Day Year <u>October</u> <u>11</u> <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 24, 1869</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN C. MONTAGUE</u>				14. MOTHER'S MAIDEN NAME <u>EMMA WILLIAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>PIERSON ROE, COROOKA, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>10-9-</u> , 19 <u>58</u> , to <u>10-11-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-11-</u> , 19 <u>58</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Paul G. Cayaves</u> M.D.				ADDRESS (Street, city or town, state) <u>222 N. Division St. - 10-13-58</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>PAUL G. CAYAVES, MD</u>				<u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Hampton Powell EASTON, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 1, 1900</u></p>	
<p>5. Place of birth: <u>John Doe, Baltimore, Md.</u></p>		<p>6. Date of death: <u>Dec 1, 1945</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>John Doe, Baltimore, Md.</u></p>	
<p>9. Signature of physician: <u>John Doe, M.D.</u></p>		<p>10. Signature of registrar: <u>John Doe, M.D.</u></p>	
<p>11. Signature of undertaker: <u>John Doe, M.D.</u></p>		<p>12. Signature of coroner: <u>John Doe, M.D.</u></p>	
<p>13. Signature of witness: <u>John Doe, M.D.</u></p>		<p>14. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>15. Signature of witness: <u>John Doe, M.D.</u></p>		<p>16. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>17. Signature of witness: <u>John Doe, M.D.</u></p>		<p>18. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>19. Signature of witness: <u>John Doe, M.D.</u></p>		<p>20. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>21. Signature of witness: <u>John Doe, M.D.</u></p>		<p>22. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>23. Signature of witness: <u>John Doe, M.D.</u></p>		<p>24. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>25. Signature of witness: <u>John Doe, M.D.</u></p>		<p>26. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>27. Signature of witness: <u>John Doe, M.D.</u></p>		<p>28. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>29. Signature of witness: <u>John Doe, M.D.</u></p>		<p>30. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>31. Signature of witness: <u>John Doe, M.D.</u></p>		<p>32. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>33. Signature of witness: <u>John Doe, M.D.</u></p>		<p>34. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>35. Signature of witness: <u>John Doe, M.D.</u></p>		<p>36. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>37. Signature of witness: <u>John Doe, M.D.</u></p>		<p>38. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>39. Signature of witness: <u>John Doe, M.D.</u></p>		<p>40. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>41. Signature of witness: <u>John Doe, M.D.</u></p>		<p>42. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>43. Signature of witness: <u>John Doe, M.D.</u></p>		<p>44. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>45. Signature of witness: <u>John Doe, M.D.</u></p>		<p>46. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>47. Signature of witness: <u>John Doe, M.D.</u></p>		<p>48. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>49. Signature of witness: <u>John Doe, M.D.</u></p>		<p>50. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>51. Signature of witness: <u>John Doe, M.D.</u></p>		<p>52. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>53. Signature of witness: <u>John Doe, M.D.</u></p>		<p>54. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>55. Signature of witness: <u>John Doe, M.D.</u></p>		<p>56. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>57. Signature of witness: <u>John Doe, M.D.</u></p>		<p>58. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>59. Signature of witness: <u>John Doe, M.D.</u></p>		<p>60. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>61. Signature of witness: <u>John Doe, M.D.</u></p>		<p>62. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>63. Signature of witness: <u>John Doe, M.D.</u></p>		<p>64. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>65. Signature of witness: <u>John Doe, M.D.</u></p>		<p>66. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>67. Signature of witness: <u>John Doe, M.D.</u></p>		<p>68. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>69. Signature of witness: <u>John Doe, M.D.</u></p>		<p>70. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>71. Signature of witness: <u>John Doe, M.D.</u></p>		<p>72. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>73. Signature of witness: <u>John Doe, M.D.</u></p>		<p>74. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>75. Signature of witness: <u>John Doe, M.D.</u></p>		<p>76. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>77. Signature of witness: <u>John Doe, M.D.</u></p>		<p>78. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>79. Signature of witness: <u>John Doe, M.D.</u></p>		<p>80. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>81. Signature of witness: <u>John Doe, M.D.</u></p>		<p>82. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>83. Signature of witness: <u>John Doe, M.D.</u></p>		<p>84. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>85. Signature of witness: <u>John Doe, M.D.</u></p>		<p>86. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>87. Signature of witness: <u>John Doe, M.D.</u></p>		<p>88. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>89. Signature of witness: <u>John Doe, M.D.</u></p>		<p>90. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>91. Signature of witness: <u>John Doe, M.D.</u></p>		<p>92. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>93. Signature of witness: <u>John Doe, M.D.</u></p>		<p>94. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>95. Signature of witness: <u>John Doe, M.D.</u></p>		<p>96. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>97. Signature of witness: <u>John Doe, M.D.</u></p>		<p>98. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>99. Signature of witness: <u>John Doe, M.D.</u></p>		<p>100. Signature of witness: <u>John Doe, M.D.</u></p>	

RECEIVED

RECEIVED

1

11892

11899

Reg. Dist. No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Lehigh</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allentown</u> 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>640 North 8th St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VIOLET</u> Middle <u>MAY</u> Last <u>Ryan</u>		4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee (Saleslady)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>	11. BIRTHPLACE (State or foreign country) <u>Allentown, Pa.</u>
13. FATHER'S NAME <u>Charles Wert</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Gruber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. William M. Ryan (Son)</u>	
17. INFORMANT <u>806 East St, Salisbury, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> 331X DUE TO (b) <u>Hypertension (Essential)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/18/58</u> to <u>10/19/58</u> , that I last saw the deceased alive on <u>10/19/58</u> , 19 <u>58</u> , and that death occurred at <u>1:35</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>Oct. 19/58</u>	
ACTUAL SIGNATURE <u>Dr. Andrew C. Mitchell</u>		M.D. <u>Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Andrew C. Mitchell</u>		Maryland Ave. Salisbury, Md Oct. 19/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 21, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Allentown, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>OCT 22 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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VS A15 (4)  
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11893

11900

Reg. Dist. No.

11893

CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE  
b. COUNTY  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
d. STREET ADDRESS

3. NAME OF DECEASED (Type or print)  
First Middle Last  
4. DATE OF DEATH  
Month Day Year

5. SEX  
6. COLOR OR RACE  
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐  
8. DATE OF BIRTH  
9. AGE (In years last birthday) 78 yrs.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
10b. KIND OF BUSINESS OR INDUSTRY  
11. BIRTHPLACE (State or foreign country)  
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  
16. SOCIAL SECURITY NO.  
17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 1. Pneumonia, Left Lung  
6000 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) DUE TO Pyelonephritis  
(c) 6 mos.  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 492x Arteriosclerotic Cardiovascular Disease  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year  
Hour o. m. p. m. 19  
20d. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/1, 1958, to 10/16, 1958, that I last saw the deceased alive on 10/16, 1958, and that death occurred at 1 P.M. from the causes and on the date stated above.  
ADDRESS (Street, city or town, state) DATE SIGNED  
ACTUAL SIGNATURE Rufus S. Gardner, Jr. M.D. PINEBLUFF Rd. 10/16/58  
PHYSICIAN'S NAME (Type) RUFUS S. GARDNER, JR. SALISBURY, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)  
22b. DATE THEREOF  
22c. NAME OF CEMETERY OR CREMATORY  
22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE  
ADDRESS  
24a. REC'D BY REGISTRAR  
DATE  
24b. REGISTRAR'S SIGNATURE

BURIAL 10/19/58 SALEM METHODIST POCOMOKE CITY, MARYLAND

Henry S. Watson Pocomoke, Md. OCT 20 '58 Arthur S. Huns

ALLIANCE STATE DEPARTMENT OF HEALTH - BALTIMORE

11894

## CERTIFICATE OF DEATH

11901

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>RD#1 ATLANTA ROAD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VERENA ANNA SIGRIST</u>		4. DATE OF DEATH Month Day Year <u>October 26, 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 6, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>SWITZERLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>FRED YONAH</u>	
14. MOTHER'S MAIDEN NAME <u>ELIZABETH VON MATT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>JOSEPH SIGRIST—SEAFORD, DELAWARE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-23</u> , 19 <u>58</u> , to <u>10-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-26</u> , 19 <u>58</u> , and that death occurred at <u>7:41</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>10-26-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT 29, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WICOMICO MEM PARK</u>	22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Medford L. Watson</u>		ADDRESS <u>SEAFORD, DEL.</u>	24a. REC'D BY REGISTRAR DATE <u>OCT 30 1958</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



AD51N 02A

BAG CONTENT

14/11/1901

14/11/1901

CERTIFICATE OF DEATH

MARITAL STATE DEPARTMENT OF HEALTH - BATHING

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Registrar		Signature of Medical Officer	
				</																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11895

CERTIFICATE OF DEATH

11902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>3 yrs. 22 da</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>--</b>			
3. NAME OF DECEASED (Type or print) First <b>Archie</b> Middle <b>B.</b> Last <b>Sinclair</b>				4. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1883</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas James Sinclair</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Bromwell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>217-03-1582A</b>		17. INFORMANT Address <b>Deer's Head State Hospital, Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General metastases</b> <b>153.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of sigmoid</b> DUE TO (c) <b>4 yrs ?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs ?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease with aortic stenosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 5, 1955</b> to <b>October 28, 1958</b> , that I last saw the deceased alive on <b>October 28, 1958</b> , and that death occurred at <b>6:27 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>10/29/58</b>							
ACTUAL SIGNATURE <b>G. Kosmahly</b>		M.D. <b>Deer's Head State Hospital</b> <b>10/29/58</b>					
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>		<b>Salisbury, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct 31, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sherwood Cemetery</b>		22d. LOCATION (City, town, or county) <b>Sherwood</b>		(State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Hampton Harrison</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

CERTIFICATE OF DEATH

11893

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HIGHEST SCHOOLING College		10. RELIGION Methodist	
11. DECEASED AT Baltimore, Maryland		12. PLACE OF DEATH Home		13. DATE OF DEATH April 4, 1968		14. TIME OF DEATH 4:00 PM		15. CAUSE OF DEATH Gunshot wound	
16. PLACE OF DEATH Home		17. DATE OF DEATH April 4, 1968		18. TIME OF DEATH 4:00 PM		19. CAUSE OF DEATH Gunshot wound		20. MANNER OF DEATH Suicide	
21. PLACE OF DEATH Home		22. DATE OF DEATH April 4, 1968		23. TIME OF DEATH 4:00 PM		24. CAUSE OF DEATH Gunshot wound		25. MANNER OF DEATH Suicide	
26. PLACE OF DEATH Home		27. DATE OF DEATH April 4, 1968		28. TIME OF DEATH 4:00 PM		29. CAUSE OF DEATH Gunshot wound		30. MANNER OF DEATH Suicide	
31. PLACE OF DEATH Home		32. DATE OF DEATH April 4, 1968		33. TIME OF DEATH 4:00 PM		34. CAUSE OF DEATH Gunshot wound		35. MANNER OF DEATH Suicide	
36. PLACE OF DEATH Home		37. DATE OF DEATH April 4, 1968		38. TIME OF DEATH 4:00 PM		39. CAUSE OF DEATH Gunshot wound		40. MANNER OF DEATH Suicide	
41. PLACE OF DEATH Home		42. DATE OF DEATH April 4, 1968		43. TIME OF DEATH 4:00 PM		44. CAUSE OF DEATH Gunshot wound		45. MANNER OF DEATH Suicide	
46. PLACE OF DEATH Home		47. DATE OF DEATH April 4, 1968		48. TIME OF DEATH 4:00 PM		49. CAUSE OF DEATH Gunshot wound		50. MANNER OF DEATH Suicide	
51. PLACE OF DEATH Home		52. DATE OF DEATH April 4, 1968		53. TIME OF DEATH 4:00 PM		54. CAUSE OF DEATH Gunshot wound		55. MANNER OF DEATH Suicide	
56. PLACE OF DEATH Home		57. DATE OF DEATH April 4, 1968		58. TIME OF DEATH 4:00 PM		59. CAUSE OF DEATH Gunshot wound		60. MANNER OF DEATH Suicide	
61. PLACE OF DEATH Home		62. DATE OF DEATH April 4, 1968		63. TIME OF DEATH 4:00 PM		64. CAUSE OF DEATH Gunshot wound		65. MANNER OF DEATH Suicide	
66. PLACE OF DEATH Home		67. DATE OF DEATH April 4, 1968		68. TIME OF DEATH 4:00 PM		69. CAUSE OF DEATH Gunshot wound		70. MANNER OF DEATH Suicide	
71. PLACE OF DEATH Home		72. DATE OF DEATH April 4, 1968		73. TIME OF DEATH 4:00 PM		74. CAUSE OF DEATH Gunshot wound		75. MANNER OF DEATH Suicide	
76. PLACE OF DEATH Home		77. DATE OF DEATH April 4, 1968		78. TIME OF DEATH 4:00 PM		79. CAUSE OF DEATH Gunshot wound		80. MANNER OF DEATH Suicide	
81. PLACE OF DEATH Home		82. DATE OF DEATH April 4, 1968		83. TIME OF DEATH 4:00 PM		84. CAUSE OF DEATH Gunshot wound		85. MANNER OF DEATH Suicide	
86. PLACE OF DEATH Home		87. DATE OF DEATH April 4, 1968		88. TIME OF DEATH 4:00 PM		89. CAUSE OF DEATH Gunshot wound		90. MANNER OF DEATH Suicide	
91. PLACE OF DEATH Home		92. DATE OF DEATH April 4, 1968		93. TIME OF DEATH 4:00 PM		94. CAUSE OF DEATH Gunshot wound		95. MANNER OF DEATH Suicide	
96. PLACE OF DEATH Home		97. DATE OF DEATH April 4, 1968		98. TIME OF DEATH 4:00 PM		99. CAUSE OF DEATH Gunshot wound		100. MANNER OF DEATH Suicide	

*James Earl Ray*

11893

## 11896 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>John B. Parsons Home</b>				e. STREET ADDRESS <b>Lexmon Hill</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LOU</b> Last <b>SLEMONS</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>15th</b> Year <b>58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Single</b>	8. DATE OF BIRTH <b>Aug. 20, 1875</b>		9. AGE (In years last birthday) <b>83</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Quantico, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Albert B. Slemons</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Ker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records: John B. Parsons Home - Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/1</b> , 19 <b>54</b> , to <b>10/15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>10/14</b> , 19 <b>58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>402 S. Division St. Salisbury, Md/</b> DATE SIGNED <b>Oct. 17 /1958</b>							
ACTUAL SIGNATURE <b>Fred R. Gramse</b>		M.D. <b>Oct. 17 /1958</b>					
PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gramse</b>		<b>402 S. Division St. Salisbury, Md/</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 18. /58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>M.E. Methodist Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11897 CERTIFICATE OF DEATH

11904  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>				c. LENGTH OF STAY IN TB <b>3yrs-16days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf, Maryland</b> <b>08X-2</b>				d. STREET ADDRESS <b>unk</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>Etta</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>5,</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1868</b>	
9. AGE (In years last birthday) <b>90</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Nathaniel Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Eugenia Lipford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>				16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT <b>Hospital Records, Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease w/coronary insufficiency</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis general</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>?</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>0</b> a. m. <b>0</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Salisbury, Maryland</b>				20g. (County) <b>Charles</b> (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>Oct. 21,</b> 19 <b>55,</b> to <b>Oct. 5,</b> 19 <b>58,</b> that I last saw the deceased alive on <b>Oct. 5,</b> 19 <b>58,</b> and that death occurred at <b>5:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>10/5/58</b>							
ACTUAL SIGNATURE <b>Dr. Juerman</b> M.D.				PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>10-8-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverside Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Richmond Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Summers Bros.</b>				ADDRESS <b>1661-600 Hope Rd. SE.</b>		24a. REC'D BY REGISTRAR <b>OCT 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		LOCATION	
AGE		SEX	
DATE OF DEATH		TIME OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
SIGNS AND SYMPTOMS		TREATMENT	
POST-MORTEM EXAMINATION		LABORATORY EXAMINATION	
FINDINGS		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS	
DATE		PLACE	



TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. TO BE ATTACHED TO THE CERTIFICATE OF DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11888

CERTIFICATE OF DEATH

11905

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN TB <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA General Hospital</u>				d. STREET ADDRESS <u>PRINCESS ANNE 19X-2</u> ✓			
3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>SOLUM</u> Last <u>SOLUM</u>				4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16 1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min <u>6</u>		IF UNDER 24 HRS Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wm. Solum</u>				14. MOTHER'S MAIDEN NAME <u>Helena Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>Mrs Ernest Stacy Salobny, Jr</u>				Address <u>Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>58</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>10-5</u> , 19 <u>58</u> , to <u>10-7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-7</u> , 19 <u>58</u> , and that death occurred at <u>10:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>10-7-58</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Perryman Cemetery near Prince Anne</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Miller</u> ADDRESS <u>Prince Anne Md.</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>OCT 15 '58</u>		24b. REGISTRAR'S SIGNATURE _____	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G234 10-17-58 et

11906

11899

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA General Hospital</u>		d. STREET ADDRESS <u>1517 Gordon Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELIZABETH THOMAS</u>		4. DATE OF DEATH Month Day Year <u>October 6, 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/19/1919</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salar</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>See Andrew Nutter</u>		14. MOTHER'S MAIDEN NAME <u>Brooksie Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Thomson</u> Address <u>5-17 Gordon St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma (uterus)</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/3</u> , 19 <u>58</u> , to <u>10/6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/6</u> , 19 <u>58</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm B Smith</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>10/6/58</u>	
PHYSICIAN'S NAME (Type) <u>DR. WILLIAM B. SMITH</u>		<u>The Medical Center</u> <u>Rt. 2, Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/10/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton Stewart</u> ADDRESS <u>Salis Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 14 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11900

## CERTIFICATE OF DEATH

11907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2 Hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
f. STREET ADDRESS <b>Merritt Mill Rd.,</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE WILSON TILGHMAN, Sr</b>		4. DATE OF DEATH Month Day Year <b>10 1 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct, 10, 1876</b>
9. AGE (In years last birthday) <b>81</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Broker</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Tilghman</b>		14. MOTHER'S MAIDEN NAME <b>Martha Emmily Adkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-8197</b>	
17. INFORMANT <b>Mr. George W. Tilghman, Sr. Salisbury, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN SET AND DEATH <b>2 Hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/1</b> to <b>10/1</b> , 19 <b>58</b> that I last saw the deceased alive on <b>10/1/58</b> , 19 <b>58</b> , and that death occurred at <b>4:45 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>10/2/58</b>			
ACTUAL SIGNATURE <b>Fred R. Gramse, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gramse</b>		<b>402 S. Division St., Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/4/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson</b>		ADDRESS <b>Salisbury, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 7 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



# CERTIFICATE OF DEATH

1900

81

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
Wm. C. Cline		Male		35		Jan. 10, 1865		Illinois		Farmer	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
Hennepin Co. Hennepin County		Jan. 10, 1900		Hennepin Co. Hennepin County		Heart Disease		Natural		1000	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
Wm. C. Cline		Mary Ann		Farmer		Housewife		Illinois		Illinois	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
Jan. 10, 1865		Jan. 10, 1865		Illinois		Illinois		Heart Disease		Heart Disease	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S CERTIFICATE NO.		MOTHER'S CERTIFICATE NO.		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
Natural		Natural		1000		1000		Illinois		Illinois	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
Jan. 10, 1900		Jan. 10, 1900		Illinois		Illinois		Heart Disease		Heart Disease	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S CERTIFICATE NO.		MOTHER'S CERTIFICATE NO.		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
Natural		Natural		1000		1000		Illinois		Illinois	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11901

## CERTIFICATE OF DEATH

Reg. Dist. No. 11908

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stockton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>E.</b> Last <b>Tull</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>14</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/17/1871</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Postmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland, Stockton</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Miles Tull</b>		14. MOTHER'S MAIDEN NAME <b>Anne Hudson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address <b>Mrs. Lillian W. Tull, Stockton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized metastases with spontaneous fracture of left femur</b> DUE TO (b) <b>Carcinoma of prostate</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept. 16, 19 58</b> , to <b>Oct. 14, 19 58</b> , that I last saw the deceased alive on <b>Oct. 14, 19 58</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Kosmahly</b>		DATE SIGNED <b>10/14/58</b>	
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>		Address <b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Oct. 17 58</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Stockton, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wayne E. Smith</b>		24a. REC'D BY REGISTRAR <b>Oct 17 58</b>	
ADDRESS <b>Snodgrass, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11901

DATE OF DEATH

11-1-1918

PLACE OF DEATH

HOME

AGE

45

SEX

MALE

RACE

WHITE

EDUCATION

HIGH SCHOOL

OCCUPATION

LABORER

CAUSE OF DEATH

HEART DISEASE

IMMEDIATE CAUSE

HEART DISEASE

PREVAILING DISEASE

HEART DISEASE

PREVAILING WEATHER

CLOUDY

PREVAILING WIND

WINDY

PREVAILING TEMPERATURE

45

PREVAILING HUMIDITY

75

PREVAILING PRESSURE

30.5

PREVAILING MOONLIGHT

NO MOON

PREVAILING STARS

NO STARS

PREVAILING CLOUDS

NO CLOUDS

PREVAILING FOG

NO FOG

PREVAILING RAIN

NO RAIN

PREVAILING SNOW

NO SNOW

PREVAILING HAIL

NO HAIL

PREVAILING Sleet

NO Sleet

PREVAILING Wind

NO Wind

PREVAILING Clouds

NO Clouds

PREVAILING Fog

NO Fog

PREVAILING Rain

NO Rain

PREVAILING Snow

NO Snow

PREVAILING Hail

NO Hail

PREVAILING Sleet

NO Sleet

PREVAILING Wind

NO Wind

PREVAILING Clouds

NO Clouds

PREVAILING Fog

NO Fog

PREVAILING Rain

NO Rain

PREVAILING Snow

NO Snow

PREVAILING Hail

NO Hail

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11909

11902

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the Health Department. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>50 Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>331 Camden Ave.</b>		d. STREET ADDRESS <b>331 Camden Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Nina Venables Veale</b>		4. DATE OF DEATH <b>10-3-1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1888</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housemother</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>College</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George C. Venables</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Langsdale</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO. <b>217-10-2286A</b>	
17. INFORMANT <b>Mrs Sara Walker, Baltimore, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>10-6-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/6/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Quantico Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Quantico, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Salisbury, Maryland</b>		24a. REC'D BY REGISTRAR <b>Oct 8 58</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kings</b>			

0702

0.000000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11910

11918

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garfield</i>				c. LENGTH OF STAY IN 1b <i>Life</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Dadie</i> First <i>Wheatley</i> Middle <i>Wheatley</i> Last				4. DATE OF DEATH <i>Oct</i> Month <i>9</i> Day <i>19</i> Year <i>58</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 17 1890</i>	9. AGE (In years last birthday) <i>68</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.		IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Guatemala</i>	
13. FATHER'S NAME <i>John M Moore</i>				14. MOTHER'S MAIDEN NAME <i>Dadie Lowe</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Maudie Welch</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO <i>degenerative heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO <i>Indefinite</i> (c)						INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>April 19 58</i> to <i>Oct 19 58</i> , that I last saw the deceased alive on <i>9 Oct 58</i> , 19 <i>58</i> , and that death occurred at <i>7:30</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>E A Farnell</i>				ADDRESS (Street, city or town, state) <i>652 W Main St Salisbury Md</i>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <i>E. A. Farnell MD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Oct 20 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Guantanamo Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Salisbury Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Boakes M West</i> ADDRESS				24a. REC'D BY REGISTRAR DATE <i>OCT 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Charles L. House</i>	





## 11903 CERTIFICATE OF DEATH

11911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>Front Street</b>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Medford</b> Last <b>Wheatley</b>				4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 8, 1866</b>	
9. AGE (In years last birthday) <b>92</b>		IF UNDER 1 YEAR Months <b>09</b> Days <b>x</b> Hours <b>2</b>		IF UNDER 24 HRS. Months <b>09</b> Days <b>x</b> Hours <b>2</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Ellen Wheatley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Deer's Head State Hospital, Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral thrombosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>11</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <b>a. m.</b> Month, Day, Year p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 21, 19 58</b> to <b>Oct. 30, 19 58</b> that I last saw the deceased alive on <b>October 30, 19 58</b> and that death occurred at <b>4:00 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. V. Maldve</b>				ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>10/30/58</b>			
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b>				<b>Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 2, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>East New Market, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 3 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krawiec</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		White		April 14, 1928		Memphis, Tennessee	
7. OCCUPATION		8. MARITAL STATUS		9. EDUCATION		10. RELIGION		11. SOCIAL SECURITY NUMBER		12. DATE OF DEATH	
Attorney		Single		High School		Methodist		1-34-567890		April 4, 1968	
13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH		16. PERMANENT RESIDENCE		17. TEMPORARY RESIDENCE		18. DATE OF INTERVIEW	
St. Louis, Missouri		Myocardial Infarction		Natural		St. Louis, Missouri		St. Louis, Missouri		April 10, 1968	
19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF DEATH REGISTRAR		21. SIGNATURE OF WITNESS		22. SIGNATURE OF DECEASED		23. SIGNATURE OF NEXT OF KIN		24. SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

*[Handwritten signature]*

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death.  
2. The cause of death should be stated in as many words as possible, and should include the immediate cause, the underlying cause, and any other significant conditions.  
3. The manner of death should be stated as either natural, accidental, or homicide.  
4. The permanent residence of the deceased should be stated as the place where he or she has lived for at least one year immediately preceding death.  
5. The temporary residence of the deceased should be stated as the place where he or she has lived for less than one year immediately preceding death.  
6. The date of death should be stated as the date on which the deceased was pronounced dead.  
7. The date of interview should be stated as the date on which the certificate was filled out.  
8. The signature of the physician or other qualified person should be written in ink.  
9. The signature of the death registrar should be written in ink.  
10. The signature of the witness should be written in ink.  
11. The signature of the deceased should be written in ink.  
12. The signature of the next of kin should be written in ink.  
13. The signature of the clerk should be written in ink.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11904

## CERTIFICATE OF DEATH

## 11912

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Raymond SPICER Wheatley</u>		<b>4. DATE OF DEATH</b> <u>October 27 - 1958</u>	
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>APRIL 3, 1891</u>
<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.		<b>10. IF UNDER 1 YEAR</b> <input type="checkbox"/> <b>IF UNDER 24 HRS.</b> <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARM owner</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FARM</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>DELAWARE</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>FRANCIS W. WHEATLEY</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNA SPICER</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>	
<b>17. INFORMANT</b> <u>MRS ROLAND C. WRIGHT - SEAFORD, DEL.</u>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>10-23-</u> , 19 <u>58</u> , <b>to</b> <u>10-27-</u> , 19 <u>58</u> , <b>that I last saw the deceased</b> <u>olive on</u> <u>10-26-</u> , 19 <u>58</u> , <b>and that death occurred at</b> <u>7:05 AM</u> , <b>from the causes and on the date stated above.</b>			
<b>ACTUAL SIGNATURE</b> <u>William R. Eklif</u> M.D.		<b>ADDRESS</b> (Street, city or town, state) <u>Salisbury, Md.</u> <b>DATE SIGNED</b> <u>10-27-58</u>	
<b>PHYSICIAN'S NAME (Type)</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>OCT 30, 1958</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>ODD FELLOWS Cem.</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>SEAFORD, DE LAWARE</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Medford L. Watson - SEAFORD, DEL.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE OCT 30 '58</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Francis</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1904

DECEASED

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Burial Officer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11905 CERTIFICATE OF DEATH

11913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>10 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		e. STREET ADDRESS <b>110 West London Ave.,</b>	
3. NAME OF DECEASED (Type or print) First <b>MARYNEAL</b> Middle <b>MARIAN</b> Last <b>WOOD</b>		4. DATE OF DEATH Month <b>10</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb, 9, 1917</b>
9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR Months <b>41</b> Days <b>13</b> Hours <b>19</b> Min. <b>58</b>	IF UNDER 24 HRS. Months <b>41</b> Days <b>13</b> Hours <b>19</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia XXXXX</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Harry E. Wood</b>		14. MOTHER'S MAIDEN NAME <b>Cornelia Plitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Harry E. Wood, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyonephlebitis</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>14 days</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> to <b>10/13/58</b> , that I last saw the deceased alive on <b>10/13/58</b> , and that death occurred at <b>2:40A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>Dr. Fred R. Gramse</b>			
ACTUAL SIGNATURE <b>Dr. Fred R. Gramse</b>		PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gramse</b> <b>South Division St., Salisbury, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/15/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 17 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krasa</b>			

Norman J. Baker





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11906

## CERTIFICATE OF DEATH

Reg. Dist. No. 11914

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ebenezer E. Harland</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/22/1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ebenezer Wright</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Phillips</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>16. SOCIAL SECURITY NO.</b>	
17. INFORMANT <b>Hospital Records</b> Address <b>Hebron, Md.</b> <b>Mrs. Etta E. Wright (Wife) Church St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Embolism of left popliteal artery</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease with left hemiplegia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aortic stenosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> Years _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 30, 1958</b> , to <b>Oct. 6, 1958</b> , that I last saw the deceased alive on <b>Oct. 6, 1958</b> , and that death occurred at <b>3:20 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Kosmahly</b>		DATE SIGNED <b>10/6/58</b>	
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital, Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 9, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Memory Gardens - R.D.#</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>OCT 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kram</b>	



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11907 CERTIFICATE OF DEATH

11915

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>127 Vue de L'eau Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Maruel Wynn</u>				4. DATE OF DEATH Month Day Year <u>Oct. 5 19 58</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/15/1895</u>			
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Worker for Welfare Dept. unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>			
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Frank Maruel</u>				14. MOTHER'S MAIDEN NAME <u>unk</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Hospital Records</u> Address <u>Salisbury, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerosis general</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 25, 19 58</u> , to <u>Oct. 5, 19 58</u> , that I last saw the deceased alive on <u>Oct. 5, 19 58</u> , and that death occurred at <u>7:35 A.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>Oct. 5, 1958</u>			
PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>									
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>Buried</u>		<u>Oct 7, 1958</u>		<u>Cambridge cemetery</u>		<u>Cambridge Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laonete Hummel Service-Md.</u>				ADDRESS <u>Cambridge</u>		REC'D BY REGISTRAR DATE <u>OCT 7 '58</u>			
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

